

MEDICAL AND SURGICAL REPORTER

No. 1719.

PHILADELPHIA, FEB. 8, 1890.

VOL. LXII.—No. 6.

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CLINICAL LECTURES.

CONGENITAL SYPHILIS.¹

BY LOUIS STARR, M. D.,

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Gentlemen: Inherited syphilis, as we see it in infants, gives us a combination of the secondary and tertiary manifestations so well known in adults, the primary lesion being absent.

The disease may show itself at three different periods of the child's existence, viz., before birth, at birth, or some time after birth. If in the first period it usually develops between the fifth and the seventh months of intra-uterine life and causes the death of

the fetus and miscarriage. Indeed, syphilis is so common a cause of the latter accident that when a woman repeatedly aborts, syphilis should always be suspected, and inquiries into the previous health of the parents be made and proper measures be adopted to save succeeding children.

When the disease is developed at birth, the symptoms are generally severe. The child, while alive, is greatly emaciated, and has sniffles and a hoarse cry. A few hours after entering the world an eruption of pemphigus appears on the palms of the hands and soles of the feet. The bullæ of this eruption, at first transparent, soon become filled with a semi-purulent matter and then burst, leaving angry looking sores. These cases may linger a few days, but almost uniformly die soon; and an autopsy reveals inflammatory spots with abscesses scattered throughout the thymus gland and lungs, and induration of the liver.

In the third group of cases the infant is often apparently healthy at birth, being

¹ Delivered at the University Hospital.

strong and plump and without noticeable symptoms of latent disease. Again, though stout and strong, an old-looking face, an inelastic, dull, and pale skin and obstinate night wakefulness, may give warning of approaching trouble. After a time, varying from two weeks to seven months, obvious syphilitic symptoms begin to be observed, the outbreak being often determined by some exanthematous attack, which leaves a specific rash in its place.

With this brief introduction let me present a case to you. The patient, a little girl aged two years, may be classed in the third group just described. She is a third child, the two elders having been "born dead." You see that she is emaciated, that her skin is pale, muddy-looking and inelastic, and that the tissues generally are flabby. The forehead is prominent; the margins of the sutures are distinct and elevated and the anterior fontanelle has evidently closed late, for although now thoroughly ossified, one can distinctly map out its position by the depression in the bones of the skull. There is a thin acrid discharge from the nostrils which has excoriated the upper lip, there are several linear cicatrices at either angle of the mouth and her voice is husky. As it is an important point in the diagnosis, observe that all of the temporary teeth have been cut. On the middle finger of the right hand there is a condition of local suppuration, threatening the loss of the nail; on the right side of the chest you see several ecchymatous pustules surrounded by a characteristic purplish margin; in the neighborhood of the genitalia and on the buttocks you notice a number of the same pustules, and on either side of the clitoris a linear mucous-patch.

This is a good picture of inherited syphilis as you will usually meet with it, but let us consider the symptoms in greater detail. The earliest sign of the disease is snuffling. Little importance may be attached to this in the beginning, indeed it is rarely mentioned without direct questioning, and then only as "a cold" which seemed to last longer than usual. But as time goes on the mucous membrane of the nose swells and then the infant begins to breathe through the mouth, and has great difficulty in sucking. In this act he will snore and often drop the nipple to rest and get a supply of air through the mouth. Soon a watery or blood-tinged discharge runs from the nostrils, reddening and cracking the upper lip

and angles of the nostrils. This, at first slight, becomes abundant and then consistent, blocking up the nares with crusts. This discharge is due to mucous patches on the Schneiderian membrane.

In severe cases ulceration occurs within the nose, which may perforate the septum nasi, or lay bare the nasal bones and lead to necrosis and flattening of the bridge of the nose—a diagnostic symptom.

Soon after coryza, skin eruptions appear. Flattened, slightly elevated spots, of iron-rust color, and often covered by minute scales, appear about the arm-pits, perineum, and genitalia. Again, there may be an erythema covering the buttocks and perineum, or invading the folds of the joints or the sides of the neck or chin having the color of the lean of boiled ham, with distinctly circumscribed edges, about which are the rust-colored spots already described.

Ecchyma, as seen in the case before you, is a common occurrence. This eruption is usually seated on the buttocks and perineum, but may appear on any part of the cutaneous surface. When the pustules are few in number each one consists of a violet-colored blotch, covered with a thick, blackish crust and surrounded by a dark-purple or coffee-colored areola. The crusts cover ulcers which are apt to deepen rapidly and leave unsightly scars. When the pustules are crowded together the areolæ join, so that all the skin of the involved area presents a red-purple or coffee hue.

In addition to the eruption described, remember that the skin of a syphilitic child is dry and parchment-like, and often scaly, particularly on the palms of the hands and soles of the feet, and that fissures are often observed between the fingers and toes, or radiating from the anus and angles of the mouth and even from the angles of the eyelids. A red, glazed appearance of the palms and soles is also to be noticed. The hairs of the eyelashes and brows often fall out and the edges of the lids become scaly. The face, especially the forehead and bridge of the nose very frequently have a yellow or *café-au-lait* color, this never extends to the rest of the body. Mucous patches may be developed on the skin or upon the mucous membrane. When on the skin, their seat is beside the anus, at the angles of the lips, about the genitals, at the arm-pits, between the fingers and toes, or anywhere where the skin is delicate and moist. They are patches of varying shape, of the consistence of me-

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cons membrane, reddish or gray in color, constantly moistened by an offensive secretion. On the mucous membrane they vary in shape, but usually appear as irregularly rounded white elevations, having in the centre a depressed point, which rapidly spreads into a simple ulcer. They may be seen in the mouth, on the fauces, or on the mucous membrane of the vagina.

A species of whitlow, as in the case before us, is often present. It consists in inflammation and suppuration of the matrix of the nail and results in loss of the nail. Sometimes every nail, both of the fingers and toes, is thus affected.

The cry is characteristic, its tone being high-pitched and hoarse, and when once heard easily recognized again. Occasionally the hoarseness is accompanied by attacks of laryngismus stridulous. Both symptoms being due, probably, to the presence of mucous patches in the larynx.

While the fontanelle of syphilitic infants is late in closing, and ossification generally is late and imperfect, the teeth do not seem to be delayed in their development and eruption; in fact, premature cutting is oftener seen than the reverse.

Bone disease is common in inherited syphilis. Parrot describes a peculiar lesion which attacks the ends of the long bones and the ossifying layer of the epiphysal cartilage. This he calls "syphilitic dystrophia;" it is a condition of suppurative osteitis of the epiphysal end of the bone affected and at first affects the layer of cartilage which is in preparation for ossification; later destructive changes take place in the bone itself. The result is separation of the epiphysis with the ossifying layer of cartilage from the shaft of the bone and suppuration about the affected region, but no involvement of the joint. This condition, when it occurs, is an early manifestation of specific taint, and usually attacks several bones, the femur is most frequently affected, next the humerus, tibia, ulna, radius, fibula, ribs, ilium, scapula, clavicle, os calcis, astragalus, metatarsal, and metacarpal bones. The symptoms are characteristic; there is complete immobility. Thus the arms may lie pronated by the side of the body, the legs may be stretched out straight in the bed, and, when the patient is lifted, hang loose and sway from side to side. Crepitation can often be obtained between the shaft of a bone and its epiphysis; the joints are tender to pressure, and when suppuration oc-

curs become bent and stiff and extremely painful.

Exquisitely painful aching nodes may develop on the shaft of the long bones and indurated masses are often discernible in the areolar tissues, tendons and muscles.

So far as the superficial glandular system is concerned, it is common to find the glands at the nape of the neck, beneath the occiput, enlarged and hardened.

Enough has been said of the general physical condition, and it is unnecessary to pause on this point further than to accentuate the marked emaciation, pallor, and universally impaired nutrition usually noticeable.

As to the internal organs, suppuration of the thymus gland and lungs have been mentioned. Gummata may also form in the lungs, and syphilitic pneumonia has been described. The liver may be hypertrophied and indurated; this when it occurs is an early lesion and is attended by pain in the belly—shown by moaning and uneasy movements of the limbs—vomiting, irregular bowel movements, tympanitic and tender abdomen, quick pulse and pinched and drawn features. Jaundice is rare; though, sometimes, the pressure of the enlarged liver upon the vena cava may produce oedema of the legs and scrotum. Local peritonitis may accompany the hepatic disease.

According to Gee the spleen is enlarged in one-half of the cases of infantile syphilis. The extent of this enlargement may be taken as an index of the severity of the poisoning, though the organ does not rapidly diminish under treatment, and may remain for years a sign of the original disease. Sometimes an enlarged spleen is the only sign of a syphilitic cachexia.

Syphilis of the heart and kidney is so seldom seen in infants that it is unnecessary to dwell upon the subject.

Let me say here that there is no uniform relation between the lesions of the internal organs and the general symptoms, one or other being accentuated as the case may be.

A peculiar form of paralysis is sometimes observed. The anterior branches of the brachial plexus are affected, resulting in more or less complete motor paralysis of the upper extremities.

In exceptional cases the manifestations of inherited syphilis remain undeveloped until the seventh or even the fourteenth year. Scaly, copper-colored eruptions, interstitial keratitis, discharges from the ears, nose and

so on may then appear. In these cases also we notice the Hutchinson or syphilitic teeth. Let us next consider the etiology. Syphilis in my opinion is usually transmitted to the child through both parents. The severity of the symptoms depends upon the time that has elapsed since the appearance of the primary lesion in either parent. It has often been stated that a healthy mother may bear a syphilitic child. I do not think this statement is correct, for I have never seen a syphilitic child infect its mother while nursing at the breast, which would undoubtedly be the case provided the child was affected solely through the father. In regard to the question of inoculation from one parent, the blame must be thrown upon the mother rather than the father.

The diagnosis of inherited syphilis is quite easy provided the symptoms described be present. If, however, there be no active manifestations, you must base your opinion upon the following: Flattened bridge of the nose, *cast-au-lait* color of the forehead, linear cicatrices about the angles of the mouth and at the anus, protuberant forehead from infantile arachnitis, chronic coryza, enlargement of the liver and spleen, general malnutrition, and if the case be old enough, the presence of Hutchinson teeth. The parental history if it can be truly elicited is of great aid in the diagnosis. The prognosis depends in the first place upon the date that either parent has presented the primary syphilitic lesion; should this be recent the child is very apt to die; if both parents be syphilitic the child is more apt to succumb to the disease than if only one parent be diseased. Again, the outlook depends upon the period at which syphilis develops in the child; thus in utero it is always fatal, while after the seventh month much may be accomplished by treatment. The gravity of any one group of symptoms does not influence the prognosis so much as the state of the general nutrition; should this be poor, death is very apt to occur.

The degree of the nasal obstruction should always be considered, for should this be extreme the child is unable to nurse sufficiently and great interference with the food supply results.

Treatment: Should one or two children in a family be born syphilitic, and another be expected, it is always advisable to treat the mother for the specific disease. It is not necessary for me to give you explicit directions, for of course you will use mercurials

or the iodide of potassium according to the stage of the disease. Should the child be born apparently healthy but with a distinct syphilitic history, anti-syphilitic treatment must be begun at once.

I prefer the mercurial treatment from the outset. Mercury may be administered by the mouth, by baths, or by inunctions. By the mouth one one hundred and twentieth of a grain of corrosive sublimate may be administered three times a day, or one twelfth of a grain of calomel thrice daily, or again, one grain of mercury with chalk three times daily, gradually increasing each dose to two grains; the last is less apt to disturb the stomach or intestines than either of the former.

Mercurial baths should be used every two, three or four days unless erythema be produced by their employment, for these baths corrosive sublimate is used, each containing 3ss of the salt; this quantity may be gradually increased fifteen grains at a time until 3i or 3iss be reached. Personally, I prefer inunctions. Fifteen grains to 3ss of mercurial ointment should be rubbed into the skin each day. In this process it is important to select a different portion of the body for each day's inunction, as the application is apt to produce an eruption upon the skin. Be careful to keep the skin perfectly clean during this treatment. Another good method of application is to smear it on the binder, the child's natural movements being successful in rubbing it into the skin.

Iodide of potassium is useful when there is much bone trouble with nocturnal pains, and in the nervous affection may either be used alone or combined with mercury.

Various local treatments are necessary, for example in cases of coryza keep the nose perfectly clean by syringing with salt and water (3i to Oi) twice daily. Touch the nasal mucous membrane every other day with a weak solution of nitrate of silver (gr. v to 3i) or blow into the nostrils three times a day a powder composed of boracic acid gr. xx to gr. xl of bismuth subnit. If crusts have formed, carefully remove them, and apply somewhat stronger applications of silver nitrate, ten or twenty grains to the ounce. If the bone is involved resort to surgical means. Ulcers on the lips should be touched with the solid stick of silver nitrate, followed by the application of dilute citric ointment or the ointment of ammoniated mercury one-half the official

strength. cleansed with calomel. I the nitrate ments. Un showed you no doubt sh syphilitic t the general wise.

PNEUMON FANT.— VIX U —TR MEN R

BY BAR ASSOCIATE PRO OF PA; P

Pneumonia

Gentlemen this morning occurred rec It is that of birth, develop ros, associat respirations, while the puls symptoms we cough, occur tion. This I suspect pneum inhalation of passage of the tract. I exam was unable t signs of pneum tion of resona and harsh res the umbilical affections of suspect either cord, and the some trouble, cough and rap called it by ex tion from the slight pulmon cided us to tre

¹ Delivered at t

strength. Patches on the skin should be cleansed with salt and water and dusted with calomel. For the eruption simply apply the nitrate or ammoniated mercurial ointments. Under such treatment the child I showed you is rapidly improving and I have no doubt she will recover. While using antisyphilitic treatment be careful to maintain the general nutrition by dietetics and otherwise.

PNEUMONIA IN THE NEW-BORN INFANT.—SCRAPING OF THE CERVIX UTERI FOR CARCINOMA.—TRUE PATULOUS FORAMEN OVALE.—TYPICAL RECOVERY AFTER LAPAROTOMY.¹

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Pneumonia in the New-born Infant.

Gentlemen: I wish to call your attention this morning to an interesting case which occurred recently in the Maternity Ward. It is that of an infant which, shortly after birth, developed a rise of temperature to 102°, associated with exceedingly rapid respirations, reaching 100 in the minute, while the pulse ranged from 120-144. These symptoms were accompanied by a constant cough, occurring with almost every respiration. This led the resident obstetrician to suspect pneumonia, due, very likely, to the inhalation of irritating particles during the passage of the head through the parturient tract. I examined the child carefully, but was unable to elicit any of the physical signs of pneumonia except a slight diminution of resonance of a small area of one lung and harsh respiration. I then examined the umbilical cord, for in acute febrile affections of the first few days of life I suspect either a disease of the lungs or of the cord, and thought that I detected there some trouble, and had it not been for the cough and rapid respirations I would have called it by exclusion a case of septic infection from the cord. The presence of the slight pulmonary symptoms, however, decided us to treat it as a case of pneumonia,

though there was nothing very definite on which to base our diagnosis. The child was given whiskey and the aromatic spirits of ammonia, and a small quantity of digitalis, and had three mustard baths every twenty-four hours. This latter is a feature of the treatment that I do not believe in as a rule, for in certain cases it will do harm. Often the shock of the bath, and the necessary manipulations prove the last straw which determines an unfavorable termination. Very likely in this case, as the baby was strong and the pneumonia not severe, it did some good by relieving internal congestion, but when the case is a bad one, our one aim should be to save every particle of the infant's strength. In *post-mortem* examinations of infants who have died from pneumonia, the right auricle is invariably found enormously dilated and engorged with blood. This strongly indicates that remedies to sustain the heart are needed in these cases, hence my reason for exhibiting the digitalis. The rise of temperature here, as you can see by glancing at this chart, began on the day following the birth of the child, and lasted for some time, but it finally sank to normal. This morning, however, there was a slight rise again, and though I had fully intended to bring the child before you, I decided not to do so.

Scraping of the Cervix Uteri for Carcinoma.

This patient is a woman, 52 years old, who has had three children. The menopause occurred two years ago, and since then she has had no show until three days ago, when it returned as a flooding. Since then she has experienced some pain. If you note the color of her skin, in connection with the history of her symptoms, you can make the diagnosis of carcinoma of the uterus with considerable assurance. Of course, vaginal examination is necessary to confirm this diagnosis; here it tells us that the case is one of papillary carcinoma, springing from the cervical pavement epithelium and extending for a short distance upon the vaginal mucous membrane. Unfortunately almost all of the cases in this hospital come to us too late to be benefited by a radical operation.

In operating for cancer of the uterus, we have three proceedings from which to choose. Our choice is governed by the progress the disease has made. We may

¹ Delivered at the Philadelphia Hospital.

resort to the excision of the cervix by high amputation, to the total removal of the uterus by the vagina, or, as I shall do in this case, because the disease has spread too far, the removal of the cancerous growth by the curette, with the application of some destructive agent to the diseased tissues necessarily left behind as the cautery, nitric acid, bromine, iodine, chloride of zinc, the chlorate of potassium, or any of the caustic agents of which we have a long list. Such an operation will help the patient greatly and improve her condition for a time at least, and it may be for years, with the very remote possibility of absolute cure. Had I seen this woman two or three months sooner, I might have resorted to a vaginal hysterectomy, but this is now out of the question as the vagina and the tissues adjoining the uterus are involved. It is not to be wondered at that such patients do come to us too late, for often there are no symptoms to attract the woman's attention until the occurrence of a hemorrhage, and in the present case this only appeared three days ago. She tells me that there had been a discharge for some time before this which she neglected, as a woman in better circumstances would probably have done.

The operation I propose doing consists in curetting away the papillomatous mass, and cauterizing the tissues left with Paquelin's cautery, care being taken not to scrape or to burn into the peritoneal cavity or the bladder. This, however, is not necessarily a fatal accident. A wooden, cylindrical speculum is needed for the introduction of the cautery, as a glass one will break, and a metal one will transmit the heat. While the patient is being etherized, I will speak to you of two other cases of some interest.

True Patulous Foramen Ovale.

At the conclusion of my last clinic, I invited a portion of the class to witness a *post-mortem* examination upon an infant which had died cyanosed. I found in the lungs evidences of imperfect expansion and of congestion, but there was neither complete atelectasis nor pneumonia. In the left kidney I found a rather curious anomaly, a very great hypertrophy, but no disease, no hydronephrosis. The supra-renal capsule was also hypertrophied. The cause of death, however, was a true patulous foramen ovale. This is a much-abused subject; many children dying in a cyanotic condition being said to have a patulous foramen. The fora-

men ovale remains patulous to a slight degree for some months after birth, at times even to the end of the first year. A true patulous foramen ovale, as I understand it, is one where no provision has been made by nature to close the opening. The flap of endocardium in the left auricle, which should close the foramen, is absent, allowing the blood to pass through the body without reaching the lungs, and as a result the child dies of a slow asphyxia. This condition is a rather rare one. In the large number of autopsies I have performed on infants, I have only seen three cases. There is a small point in the technique of looking for this condition, which is worth remembering; that is, the way of removing the heart from the chest. It is well to make one's incision from the ascending cava upward, slitting open the right auricle on the anterior, upper, aspect. Catch the ascending cava between the thumb and the forefinger of the left hand, lift it well up, snip it across with scissors, remove the heart by severing its other attachments, still, however, holding it by the ascending cava, then open the auricle by inserting the scissor's point well within it through the ascending cava. This method gives a good view of the foramen ovale and the eustachian valve.

Typical Recovery after Laparotomy.

Some time ago I referred to the fact that in the two laparotomies I had last performed, I had found abdominal abscesses. I overhauled and cleaned my instruments in order to remove any possible cause of infection, but I am strongly inclined to believe that they resulted from my fingers coming in contact with the clothing of some of the spectators. I therefore resolved to use greater precautions in this respect in my subsequent operations. Consequently the next operation I performed was a perfect success in every way, and the next one was the most typical case of recovery I ever observed following a laparotomy. I show you here the dressing next the wound removed in one week, perfectly dry, without even the linear stain which is commonly seen upon it. There was perfect union of the wound by first intention. The temperature here was regular, as much so as in any of us, with no fever.

Our patient being now under ether I will proceed with the operation. One needs but few instruments for this operation. A large curette, with serrated edges is best; a vol-

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cella to pull down the cervix; a sound to locate the cervical canal if necessary; and the blunt tip of the Paquelin's cautery, to avoid penetrating into the peritoneal cavity. Should the cautery fail to work I shall resort to the employment of fuming nitric acid. The proper heat for such a cauterization is a cherry red. Many cauteries are ruined by overheating, the spongy platinum at the end being fused.

If I should find, on examining the patient under either now, that the extension of the disease is less than at a rather hasty examination first appeared to me, I shall not do the operation I have suggested, but shall have her carried to the ward, and shall later remove the uterus through the vagina. Before examining her I will have the vagina washed out with a bichloride solution. This may seem unnecessary, but it is a wise precaution to take, as the micro-organisms with which the vagina is now swarming, will be washed away and destroyed, and as I use the curette the whole system will not be infected as it otherwise might. It is a curious fact that these cases rarely die of septicemia. This is due to the fact that the process is a slow one, and nature throws out around the malignant mass a strong barrier of indurated tissue which prevents the invasion of the germs of putrefaction. These patients die usually of exhaustion, of hemorrhage, or of anemia from involvement of the bladder and ureters with retention of the urine.

I find here that the disease has extended into the vaginal connective tissue and over towards the side of the pelvis. It would be criminal to remove the uterus, as in so doing I would infect her in all probability, and at any rate there would be a continuation of the disease. I shall, therefore, proceed to curette the cervix. The hemorrhage which occurs during the curettement is sometimes alarming, but one should remember that when he gets past the cancerous structure the hemorrhage will almost cease, so the more energetically he currettes, the less the hemorrhage. I find a cavity here extending almost to the peritoneum, hence I must proceed with care. Here in front is another place in which the disease has almost entered the bladder. Here you can see the considerable amount of tissue which I have removed, and there is almost as much diseased tissue remaining. I dare not scrape there as I would like, for the disease has progressed further than I expected, and there is but a thin partition between the excavation

and the peritoneal cavity. In case of a large soft mass when we fear perforation, the finger is the best curette, but when the growth is denser and firmer we must again use the curette. It is remarkable that the woman had not a hemorrhage sooner, as there is a most extensive excavation here penetrating into the connective tissue toward the broad ligament, and anteriorly almost into the bladder, while posteriorly I fear it has gone all the way down to the peritoneum.

I shall now clean out the vagina with some cotton. Then use the cautery to destroy the cancerous material I have been unable to remove. It is, in addition, one of the best of antiseptics, and its thorough application to the vaginal vault, at the bottom of a long cylindrical speculum, is facilitated because it acts as an excellent illuminator. The patient should suffer no pain after this cauterization unless I have gotten into the peritoneum. I burn this more thoroughly than I should ordinarily, because I was unable to remove all the growth with the curette. As there is some little bleeding here I will insert a tampon of wool with iodoform. This will be removed in thirty-six hours. She will get enough opium to make her comfortable. She is doomed in all likelihood to suffer most excruciating pain in the near future. In that case I would encourage her to take opium continuously to the degree of partial narcotization. It is possible that the operation itself may prove fatal, for the disease is in an advanced stage, and I may unconsciously have penetrated the peritoneum. She will otherwise probably die in from three to six months, very likely from uremic complications.

HOT WATER PLANTS.—J. Walter Fewkes has an interesting paper in the May number of the *American Naturalist* on the vegetation of hot springs. That vegetation can exist in these hot springs—the highest temperature on record in which it occurs is 200° Fahr.—indicates that vegetation may have occurred at a much earlier stage of the earth's history than has been generally supposed. The prevailing form of vegetation in these heated waters is algæ. Diatoms also occur, but sparingly. They have been found in Nevada at a temperature at which the vegetation of hot springs is most flourishing, but usually occur in great abundance in the cooled waters of hot springs.—*Popular Science News*, Feb., 1890.

COMMUNICATIONS.

REPORT OF A CASE OF ABDOMINAL SECTION.¹

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SURGEON-IN-CHIEF, KENSINGTON HOSPITAL FOR
WOMEN, PHILADELPHIA.

**Acute Pyo-salpinx, and Abscess of
the Ovary, following Abortion.—
Woman in Desperate Condi-
tion of Prostration from Sep-
sis.—Laparotomy with re-
moval of Tube and
Ovary.—Recovery.**

On Tuesday, December 31, 1889, Mrs. Y. applied for treatment at my clinic at the Northern Dispensary. She gave the following history: German; twenty-three years old; married one year; always healthy until present illness, which dated back to a miscarriage at the third month, seven weeks previous. The physician in attendance told her that the fetus was putrefying. He emptied the uterus manually, and used no douche afterward. The following day, as she was without money, word was sent the physician that he should not call again. She was in bed six days, and then got about the house. During this time there was constantly a bloody, foul-smelling discharge, but no chill. Later she attempted housework, but suffered so much from pain in the right iliac region that she was obliged to give it up. The discharge continued, and the pain grew worse until she was compelled to go to bed, some days before applying at the clinic. She had become so weak from recurring chills, sick stomach, inability to eat, and pain, that she required the assistance of her husband to walk. On examination the skin was found hot and dry, pulse 160 and weak. The pelvic cavity was filled with a semi-fluctuant mass extending from the right wall of the pelvis to the uterus, which was displaced against the left wall of the pelvis. This mass was not very tender, was not attached to the pelvic wall or vagina, and was clearly a tubo-ovarian abscess, and not an abscess in the broad ligament. The abdomen was not excessively tender, and there was no evidence of peritonitis.

The vagina contained a considerable quantity of foul-smelling discharge. She was extremely sick, and the outlook for recovery was bad. She was advised to enter the Kensington Hospital for Women for operation, after preparatory treatment. Mrs. Y. was sent home to bed, hot carbolized douches ordered, and she was put on co. licorice powder, and quinine, with deod. tr. opium to relieve pain, poultices over the hypogastrium, together with such liquid diet as she could take. The following day she was better—her pulse was 120, and her temperature 102° F.—and the treatment continued. The next day the pulse was 110 and the temperature 100° F. and she was admitted to the Hospital late in the afternoon.

My intention was, if possible, to get her in such condition that abdominal section could be done, and the abscess removed with a prospect of a cure. But the jarring incident to the removal to the Hospital made matters worse. The following morning she had a septic chill; pulse 150; T. 105° F.; skin "leaky;" face anxious; but no signs of peritonitis. Antipyrin (grs. v) was given, with stimulants, and the patient was bathed with alcohol and water. Under this treatment apparent improvement followed for some hours; to be followed later by a steady rise in the pulse rate and temperature. It became plainly evident that the patient would shortly die unless relieved of the pus. In her weakened condition it seemed probable that death would result from shock, were an attempt made to remove the abscess by laparotomy. Hence I felt inclined to tap per vaginam as a palliative measure. Mrs. Y. was removed to the operating table, etherized, and examined. Under ether it was quite plain that the abscess was not attached in Douglas's pouch, and I considered that tapping per vaginam would result in letting the pus into the cavity of the peritoneum, and cause septic peritonitis, and early death. Therefore, laparotomy was decided upon as affording the only hope of recovery. Everything being ready, it was immediately done, in the presence of Drs. Boyd (assisting) and Applebach, and the nurses.

On opening the abdomen and passing two fingers into the pelvis, a large fluctuating mass was felt, occupying almost the entire pelvis, and displacing the uterus against the left pelvic wall. On touching this, pus gushed forth and a large part of the ovary floated to the surface. An immense tube, of a calibre in places of an inch

¹ Read before Northern Medical Association, Jan. 24, 1890.

and six adhesions was then removed. F., to remove the pint of watery, toneal cavity, portion of the ligated, and minutes. found peritonitis removed. thoroughly between the pouring was over the on assisted by uterine post consumed as the patient the influence intensely stupor and cision were wet with drainage-tube closed, the patient put when she pulse was 120 to bed the During the was used to its influence avoided. Mrs. Y. The gauze was daily, and the discharge was normal with no. The stomach days; union site of the closed. The attended to the amount in half-hour. water were given limit of tolerance by the mouth. ally were used the nourishment for chills. cines stopped with glycerine. This makes which have recovered. The happy

and six inches long, was separated from adhesions and delivered. The pelvic cavity was then irrigated with boiled water, of 110° F., to remove the sanious pus, probably a pint of which had escaped into the peritoneal cavity. The tube and remaining portion of the ovary were carefully washed, ligated, and removed. This occupied fifteen minutes. The other ovary and tube were found perfectly healthy and were not removed. The peritoneal cavity was again thoroughly irrigated by pumping water between the intestines with a syringe, and by pouring water from a pitcher, more especially over the omentum. The cleaning process was assisted by sponging the ante- and retro-uterine pouches, and the iliac fossæ. This consumed ten minutes, but was not hastened, as the patient's condition improved under the influence of the hot water. Owing to the intensely septic character of the pus, the stump and the edges of the abdominal incision were wiped with a sponge moderately wet with bichloride solution, 1-2000. A drainage-tube was inserted, the incision closed, the dressings applied, and the patient put to bed in better condition than when she left it. Before operation the pulse was 140; temp. 104° F. When put to bed the pulse rate had fallen to 120. During the operation only enough ether was used to keep the patient gently under its influence, profound narcosis being avoided.

Mrs. Y. made an uneventful recovery. The gauze was removed from the tube twice daily, and the tube removed after 54 hours. The discharge was moderate. The temperature declined from day to day, became normal within the first week and remained so. The stitches were removed after six days; union by first intention, except the site of the drainage-tube, which shortly closed. The after-treatment was carefully attended to. Champagne was given, and the amount increased to two drachms every half-hour. Beef tea, and milk and lime water were given after twelve hours to the limit of tolerance of the stomach. Digitalis by the mouth, and strychnia hypodermically were used during the first day. Later, the nourishment was pushed, sherry substituted for champagne, and the other medicines stopped. The bowels were kept open with glycerine and turpentine enemata.

This makes my tenth laparotomy, all of which have recovered.

The happy result in this case was more

than one could expect, and is an illustration of what can be accomplished at times under adverse conditions. The favorable result was due to several causes. The septic chills were probably from the absorption of ptomanes from the pus, and not to true septicemia. While the tube was everywhere adherent the adhesions were easily separated, much time being thus saved, and shock avoided. The thorough irrigation doubtless did much to promote recovery, both by removing septic pus, and stimulating the nervous system. Even with thorough irrigation it is truly wonderful that these patients escape septic peritonitis, when virulently septic pus has been poured among the intestines. The drainage-tube in this, as in all pus cases, relieved the peritoneum of much fluid. The *morale* of the patient was good; and was assisted by the nurses, who find it difficult to believe that any one can die after abdominal section.

The proper management of such desperate cases, seen late, is a most interesting question. Cases of true pelvic abscess—not uncommon after labor, less common after abortion, and extremely rare in non-pregnant cases—should undoubtedly be evacuated per vaginam, or above the pubes, without opening the peritoneum; or in some cases after an exploratory laparotomy for diagnosis, and for fixing the site of incision. The sooner such abscesses are evacuated the better. The management of certain cases of pyo-salpinx and tubo-ovarian abscess is not so plain. When the patient's condition is good prompt removal of the diseased appendage is the recognized method of the treatment. But when the patient's condition is such that a little shock will kill, there is room for true conservatism and discrimination.

In acute cases time and proper medical treatment almost always brings improvement, and a better opportunity for saving the patient by operation. The history of such cases is that of many recurring attacks of serious illness, followed by improvement. Operation when the patient is prostrated is likely to be followed by death from shock; hence my rule is to wait until the acute symptoms have subsided, and the patient has had an opportunity to recruit her strength. But there are exceptional cases—as illustrated by the one reported—which must be operated on at once, as the only means of saving life. If the tubo-ovarian abscess is small, and the condition

principally a peritonitis which tends to spread, laparotomy with separation of adhesions, emptying all pus sacs, removal of the diseased appendages, irrigation and drainage is demanded. The same is true of large abscesses in which there is little complicating peritonitis, so that the general peritoneal cavity is not shut off, by intestinal and omental adhesions, from communication with the sac of the abscess. In such cases tapping per vaginam would almost surely result in leakage of pus into the cavity of the peritoneum, septic peritonitis and death.

In cases of large pyo-salpinx and abscess of the ovary, in which the viscera are matted together and the pelvic cavity isolated; cases in which during an acute attack of pelvic inflammation the life of the patient is threatened by sepsis, the pus can be evacuated per vaginam, the crisis be safely passed, and an opportunity be given for the successful removal of the diseased appendages later, when immediate operation would almost ensure death from shock. There is no doubt that a cure may at times follow vaginal tapping of abscesses of the uterine appendages, but I believe that tapping should be regarded as a temporary expedient of value under the conditions named, and not as a means of cure.

To wisely discriminate in these acute cases of pelvic inflammation, to decide which cases shall be treated by medical means alone, which shall be subjected to abdominal section at once, and which to palliative tapping, requires the exercise of the greatest care and judgment on the part of the surgeon.

FUNCTIONAL NERVOUS DISTURBANCES CURED BY THE CORRECTION OF ERRORS OF REFRACTION.¹

BY GEO. N. KREIDER, A. B., M. D.,
SPRINGFIELD, ILL.

It has been known for some years that certain headaches and other pains in the head called neuralgias were due to gross errors of refraction and were curable by proper glasses, but it is only recently that we have learned what great disturbances could

be caused by very slight errors of this nature and how important it is to pay attention to them before proceeding to the medical treatment of all functional nervous derangements. One case of mine will serve to emphasize this statement. Miss H., now 19 years old, consulted me in 1883, for severe headaches, which persisted in spite of all my medication. Suspecting trouble with the eyes, I referred the case to Dr. Prince, and was much humiliated to have her returned with a note stating that the error was so slight that it was not worth correcting. In June, 1889, the lady's mother again mentioned her headaches to me, and having forgotten the previous testing of her eyes I suggested an examination of them. She immediately recalled the fact that Dr. Prince had already examined them six years before and pronounced them all right. "Well," I replied, "bring her in again without fail, for doctors have learned a good deal about these cases since the time of that examination." She did so, and the error, which now amounted to $\frac{1}{2}$ dioptric, was corrected and the neuralgic headaches have been entirely cured. As I said before, I mention the case to show that specialists themselves are only waking up to the importance of compensating slight abnormalities.

The attention of the entire profession should be called to this important subject. It does not require much study nor money for a general practitioner to so sufficiently acquaint himself with the methods of examination as to know when a glass is required. Of course he should not attempt with this slight knowledge to prescribe a glass but should refer the patient to the nearest competent specialist for a thorough examination under the influence of atropine. By means of Dr. Culbertson's prisoptometer one can make this preliminary examination. The instrument only costs about \$25. I need not give a description of it, as it is simplicity itself, and its manipulation can be learned in an hour.

Up to this time my experience has been confined to the treatment of epilepsy, neuralgia, headache, and constipation. My most remarkable experience has been in the treatment of two patients who had suffered for a long time with epilepsy. One Fred. C., 19 years old, had suffered from attacks of petit and grand mal for a period of five years. The first attack came on in the evening after a day's work plucking corn. This

¹ Read at the fourteenth semi-annual meeting of the District Medical Society of Central Illinois, Nov. 12, 1889.

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form of labor requires constant use of the eyes in a stooping position, as you all well know. An interval of a year followed without any attack, when a second spasm followed after a day's work at the same labor. Following this last-mentioned attack the fits were numerous, and not controlled by any medicine, which he took as prescribed by one of my colleagues in Springfield; and which, I presume, consisted largely of bromides. When he consulted me my attention was called to the peculiar appearance of his eyes, and I was also impressed with the fact that his first two attacks had come on after plucking corn, as I have already stated. I immediately examined his eyes and found that my suspicion was correct. I referred him to Dr. Prince for more thorough examination

and he found R. $+1.25$ DC $+5$ DS 90° L. $+2.5$ DC $+25$ DS 90° and prescribed the proper glasses. His epilepsy was to a large extent but not altogether controlled by this means alone. The dissipation and surroundings of the patient I believe only prevented a complete cure. The study of this case taught me a lesson, and in the case of Julia McC., whom I had been treating for about a year for epilepsy with only fair success, the next time she put in an appearance I examined her eyes and found an error which Dr. Prince proved to be only $\frac{1}{4}$ dioptric for each eye. She put the glasses on and has worn them since January, 1889. She has had no spasm since July, 1888, and has not taken any medicine at all since May, 1889, a period of about six months. She is no longer constipated and the yellowish color of the skin has disappeared. She frequently suffered before from severe headaches, but has only had one since wearing the glasses and that only slight. That she had genuine epilepsy, and that for a period of ten years, I think there is no doubt. Those who have seen her during one say that they begun with a look and cry of terror, then followed violent twitching, frothing at the mouth, and biting of the tongue. I have seen the lacerations of the tongue myself and can therefore bear witness that they actually existed.

I have the following cases of neuralgia and headache to report as cured by proper glasses:

Sigmund L., fruit merchant, 25 years old, suffered almost constantly with neuralgia or headache, involving particularly the region over the eyes. His eyes were plainly on a constant strain, although he wore glasses

prescribed for him by a charlatan who recently infested our city. He was found to have a quite remarkable error which was only fully corrected when atropine was used. It amounted to

R. -5 DS L. -5 DS
 -1 DC 45° -3 DC 45° .

When the proper glass was at last fitted he gained complete relief. He takes no medicine to prevent his headache and when he does have them, averaging about once a month, they are very light.

Mr. Geo. W. M., 32 years old, is another case who suffered greatly from neuralgia and other obscure nervous symptoms, and who was relieved by R. $+1.75$ DC $+5$ DS L. $+2.5$ DC $+25$ DS glasses.

Miss Ella T., a high school student, has irregular menses, constipation, headaches, and hysterical attacks which were largely relieved by correction of her error, amounting to $+25$ DC $+5$ DS 90° for both eyes.

Mr. L. B., of Peoria, suffered greatly from neuralgia, which was only relieved after an examination and correction of a slight error had been made.

Sister C., Catholic school teacher, suffered from headaches and constipation, which symptoms were greatly relieved by glasses.

Some of the most interesting of my cases have been females on whom I had already operated or had treated for uterine difficulty. I supposed their neuralgic head pains were altogether due to the manifest uterine disturbance, but as that symptom persisted after a cure of the laceration or version I had them examined for glasses and secured its amelioration.

Mrs. Jos. E., 28 years old, had an extensive laceration of the cervix uteri with the usual symptoms of pain in the back and limbs, top of the head, etc. She was operated on with an excellent result. Head pains still continuing, I accused the eyes of a part of the crime and found them guilty. The error amounted to $+5$ DC 90° in both eyes. Since it has been corrected her relief has been marked, although, because of her pride, she will only wear the spectacles in reading.

Mrs. R., 25 years old, is a case almost identically like the one just mentioned. Her error was greater, however, amounting to R. $+1$ DS $+1$ DC 90° and L. $+1$ DS $+1.75$ DS 90° . The relief afforded was very marked. I

have treated three other cases with a similar history, but they have not been tested long enough to allow me to make any statement regarding them.

I hope it will not be supposed that because I have selected the subject of the cure of functional nervous disturbances by the correction of errors of refraction that I have taken up the specialty of the ophthalmologist, nor that of the neurologist, but have had simply in mind the helping of my brother general practitioners over what may be to them difficult places. I take great delight in treating diseases by mechanics rather than by physic, or, if I may be allowed to pluralize it, physics, and these cases are just in that line. Their relief has been a source of great satisfaction to me.

CREMATION.

WHAT IS THOUGHT OF IT BY PHYSICIANS.

INTERVIEWS WITH PHYSICIANS BY A REPRESENTATIVE OF THE MEDICAL AND SURGICAL REPORTER.

EIGHTH SERIES.—BUFFALO.

DR. CHAS. CARY, who is President of the Buffalo Crematory Company, says: I am an advocate of cremation both on scientific and on sentimental grounds. It was first brought forcibly to my attention by the death and cremation of my father. At the time his cremation was a shock to me, on account of the unpleasant notoriety then connected with this method of disposing of the dead. I have gradually come to regard cremation, not with a feeling of indifference, but as decidedly to be preferred to burial, not only for hygienic reasons, but from the standpoint of sentiment. Dr. Frederick Peterson, now of New York, was the first to agitate the question of cremation in Buffalo. The first organized movement in this direction followed a paper read by me on the subject before the Buffalo Medical Club, setting forth the advantages of cremation and advocating its introduction. An informal set of resolutions, favoring cremation and advising its introduction in Buffalo was drawn up after the reading of the paper, and was generally signed by the

members of the Club. Some three years later, the formal organization of the Buffalo Crematory Company was effected. On its Board, of nine, there are three physicians, and many other doctors are among the subscribers to the fund. Several physicians and members of physicians' families have been cremated, and several other physicians have made requests that their bodies should be cremated; which requests have been disregarded. Since the completion of the Buffalo Crematory, in February, 1886, there have been sixty-five cremations, the number having increased each year; although during this time six other crematories have been built in other States than New York. The Board of Health recognizes cremation as a legitimate mode of disposing of the dead and grants permits for cremation. Buffalo has been exceptional in the interest shown in cremation. The Buffalo crematory was the third to be established in this country, having been built at about the same time as the one in New York. It was the first crematory in whose construction the idea was carried out of adding a chapel to the furnace, and of having the surroundings in keeping with the solemnity appropriate to death. The supporters of the Buffalo Crematory are among the most intelligent and representative citizens of the city, and they number not only physicians, but lawyers, business men, and others who have become interested in cremation with no professional prejudices. At the time of the organization of the Crematory Company, some opposition was anticipated; but there has been little or none. Cremation has been preached from three pulpits in this city.

DR. D. W. HARRINGTON, when asked for his views concerning cremation, replied sentimentously, I am vice-president of the Crematory Company and a large stockholder in it. I favor cremation for sanitary reasons.

DR. ROSWELL PARK says: I believe in cremation as the rational and sanitary way of disposing of the dead. There can be but one objection to it, and that is the sentimental. People accept or reject cremation mainly on sentimental grounds, and are not amenable to reason or argument in the matter. Personally, I consider it preferable even from the standpoint of sentiment. I have seen several cremations, and I think there is nothing about the process to offend any sensibility, and that a number of people who are opposed to it simply because they

do not know how it works in practice, would have their views changed by witnessing a cremation. The various attitudes which clergymen of different denominations take concerning the matter, *pro* and *con*, show that there is nothing in orthodox or other religious views which cuts any particular figure in the consideration of the subject. The Romish Church to-day is violently opposed to cremation; but two or three hundred years ago they were anxious to burn people even before they were dead. The present attitude must be viewed as one of reaction.

DR. M. D. MAUN says: I have nothing to say in addition to what Dr. Park has said, except that, if a person could see an exhumed body some weeks after interment, it might have great influence in changing his sentiments in favor of cremation. Certainly the process of decomposition which takes place under the ground is more disgusting and horrible than anything that can take place in the furnace, and the result is the same in the end. Between having the body destroyed by bacteria and by fire, I should prefer the fire.

DR. W. S. TREMAINE says: I am in favor of cremation. I do not know that it is necessary as a sanitary measure in small places, but in larger cities it is a clean, healthful and cheerful way of disposing of the dead. The precaution should be taken of having bodies examined by some competent physician in all cases before incineration, partly to do away with the slight danger of burning a live person, but more to avoid the hiding of evidence of poisoning. If that danger is guarded against, as it can be, there should be no objection to cremation. Unfortunately not all our medical men are competent to decide the question of poisoning, and cremation might possibly afford a mode of concealing the commission of crime. A columbarium ought to be associated with every crematory, so that the ashes of the dead may be disposed of in urns. Or, a cemetery of less extent than at present required might be used for the burying of the ashes. In this way all the sanitary objections to our present method of burial would be done away with and yet all the sentimental features would be preserved.

DR. H. R. HOPKINS says: I believe in cremation in a limited sense, as the safest means of disposing of the remains of those dying of infectious or contagious diseases. I believe that the question should be kept before the medical profession, and thus in-

directly before the people at large, until public opinion is developed to the extent of having statutory provision directing that the remains of those dying of such diseases shall be disposed of by cremation, arrangements being made by municipalities to carry out the provisions of such statutes at the expense of the State: this to be done as part of the quarantine or police regulations of municipalities, towns or counties. I believe that cremation possesses, to certain people, advantages in the way of sentimental considerations, and that private enterprises should be encouraged to offer such advantages to those who are pleased with them. I do not want to advocate that there should be statutory provisions directing the cremation of all mortal remains. I do not think there is a demand for such general cremation. Ultimately, I think, people will look upon cremation as the final triumph of medicine, in the broad sense, over disease. In a great many instances, from the nature of the conditions, we pursue a losing fight, and, in spite of every effort, disease gradually wins the victory. Cremation offers an opportunity to pursue the battle a step further, and it will be to a great many people a source of satisfaction to know that, even if the disease has destroyed the life of the patient, yet ultimately the disease itself has been exterminated, and that the ashes which remain after incineration can be regarded as absolutely free from any kind of disease.

DR. JOHN CRONYN says: We are now in the nineteenth century, an age of progress, and I am opposed to going backward to the methods in vogue among the heathen. I am opposed on principle to cremation. In large, over-crowded towns, when an epidemic disease is in progress and there is no adequate means of disposing of the dead by burial, cremation might be considered proper.

DR. THOMAS LOTHROP says: I have never given the subject of cremation much thought. I think the best way to consider such a question is to bring it home to one's self, and to ask: What disposition would you want made of your body? In my own case I should much prefer the older method of burial. At the same time I should not oppose cremation. As the thing stands at present I should think it was a matter of choice. There is no urgent necessity for cremation: for there is plenty of room to bury the dead. If ours were a thickly populated country like England, it would be

quite different. Here, there is no danger of contamination of drinking water by percolation from the burying-places of the dead.

DR. ERNEST WENDE says: I favor cremation, not so much as a matter of economy, nor as preventive for premature interment, nor as an interposition to the desecration of God's Acre, but solely upon hygienic grounds. I advocate the process of cremation as purely philanthropic, and its adoption by legislation; for the disposal of the dead by burial is a dangerous and most unsanitary plan. Especially will this be true as our country becomes more densely populated. That the living may not suffer, the body of the ignorant, the bigoted, and the prejudiced should likewise be compelled to burn.

DR. WM. C. PHELPS says: I believe in cremation as the nicest way to dispose of a dead person. I am a stockholder in the crematory. We dispose of the remains of the subjects used in the dissecting-room by cremation. We have a small crematory in the college building, the fuel used is natural gas.

DR. MARCELL HARTWIG says: I can but say that, to my view, the subject of cremation is causing an undue amount of excitement wherever discussed, essentially because of the great quantity of true and false bigotry prevailing.

When mankind shall have learned to distinguish facts from theory or hypothesis, the hot discussions about the value of cremation will subside, and our bodies will be cremated generally, unless some prefer to remain useful even after death, and have their skins tanned into leather and their remains incinerated in the fertilizer works, to form suitable food for the golden grain, in order to help the poor to be clad and fed. If there is a single objection which looks as though it were not to be easily refuted, it would be the danger of cremating the evidences of crime; but others have shown that this danger is not any greater than that from burying it. A prosecutor at every crematory would readily prevent it, not to speak of the incalculable boon to medical science which such an institution would confer.

A NEW operation for epilepsy, recommended by Dr. William Alexander, of Edinburgh, consists in the removal of the cervical ganglia of the sympathetic.

RHINO-PLASTY.

BY DR. GEO. GOODHUE,

DAYTON, OHIO.

Of all parts of the face that give character and expression the nose ranks pre-eminently first; and hence its loss or mutilation results in the greatest possible deformity. In the olden time, when it was the custom to punish evil-doers by cutting off the nose, to the deformity was added the stigma of crime.

At the present time in civilized countries the loss of this organ is so generally due to syphilis that now to the deformity is added the brand of immorality. Hence it is not surprising to find that from the earliest time down to the present, restoration of this organ has been demanded of surgeons by operative interference. The art has been practiced in India from time immemorial. Celsus speaks of the operation in his cyclopedia of medicine. In the sixteenth century a new method of operation was introduced by Taliacotius, an Italian surgeon, who wrote a work on nasal autoplasty, which is still in good repute. In the present century it has been largely practiced in Europe and with marked success. In America, too, it has had many enthusiastic advocates, and been practiced with brilliant results, especially in the hands of Dr. Warren, of Boston, and Prof. Pancoast, of Philadelphia.

In rhino-plastic operations there are two methods from which we may choose, the Indian and the Italian. In the Indian operation the tissue is taken from some contiguous portion of the face, in the Italian, from some distant portion of the body, generally the arm. The so-called French method is but a modification of the Indian, and the German a modification of the Italian, neither deserving the honor of a distinct name.

When crime was punished by cutting off the nose, the portion removed was often replaced and so frequently found to grow again that the excised portion was ordered to be burned.

But attempts to transplant foreign tissue upon nose stumps refreshed, without leaving an arterial supply, has proved futile, and whatever method we apply one end of the flap is left attached until the other end has united with the nose. The Italian method, on account of the painful confinement of the head and arm, is now seldom employed; and we choose the older or Indian method,

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with perhaps modifications, as was the case in the operation which I will now report.

The patient, female, was 46 years old, of German descent, married, and mother of one child, and in quite feeble health.

She had several large scars on one arm and one on her left cheek; and end of nose, including both alæ and cartilages, gone. She was sent to me in the early part of June, 1887, by Dr. Hooven, to get my opinion in regard to operation for restoring the lost member. In conferring with the physicians under whose treatment she had been for the last three years, I found that these sores were of a specific character and had been very obstinate in healing, especially the one on the end of the nose; but finally they had all yielded and she was left with this terrible deformity.

Although she was unconscious of the cause of her trouble and not especially æsthetic in her tastes, her appearance was so wonderfully marred that she could not tolerate the gaze of passers-by which her deformity attracted, and fairly besought me to make an attempt to build her a new nose.

I reluctantly complied with her request, knowing that several cases had resulted fatally and many attempts had fallen short of the end desired, and the patient was left the original deformity plus a scar of greater or less magnitude on cheek or forehead from which the material was borrowed for construction of a new nose. Having decided to make the attempt, my patient was put on iodide of potash for eight weeks, which very materially improved her general condition.

On August 18, 1887, with the valuable assistance of Drs. J. M. Weaver and H. O. Collins, I made my first operation. I chose the right cheek as the site from which to obtain tissue for transplantation because of the presence of scars on left cheek, and there would not be the necessity of twisting the pedicle of flap as would be the case had I selected the forehead; and, hence, I would be more certain of abundant arterial supply, which, of course, is of the utmost importance in the transplanting of so large a flap as this operation necessitates.

I had previously made a leather flap of proper dimensions to fit the nose stump and restore as perfectly as possible the size and form of the lost organ. This leather flap when increased about one-fourth to allow for tissue contraction it measured 4 inches in length and $2\frac{3}{4}$ inches at its greatest breadth. This model was placed on the

cheek and outlined by nicks with a scalpel which served as a guide in cutting my flap for transplantation, which included all the tissues overlying the muscles; care being taken not to wound the angular artery.

As soon as the hemorrhage had largely ceased and wound had been bathed with a 1 to 5000 solution of bichloride of mercury the flap was returned to its original site and covered with cotton soaked in a hot bichloride solution of the same strength, in order that the flap might not become chilled. The nose having been plugged with cotton, its edges were pared for the reception of the new material, and at this point we met with the most tedious part of the whole operation. The hemorrhage, while it was not profuse, was constant and seemed almost interminable.

To insure primary union, torsion and bruising of the bleeding surfaces was carefully avoided, and hot water and gentle pressure were the only hæmostatic agents that we felt justified in employing.

Finally the new tissue was firmly and accurately stitched to the nose stump by ten sutures of antiseptic silk; rubber tubes were introduced to maintain the natural calibre of the nostrils. Iodoform was plentifully applied covered by antiseptic gauze and all overlaid with an abundance of borated cotton held in place by adhesive plaster.

My patient rallied well from the anæsthetic, although the hemorrhage had necessitated its employment for nearly three hours. She suffered no pain and very little inconvenience. On the fourth day dressings were removed and primary union found to have taken place everywhere except at the end of columna nasi, which was remedied by subsequent operation. Five of the sutures were removed and dressings reapplied. On the sixth day dressings were removed and also the remaining sutures. Nothing more was done for four weeks, when the pedicle was severed and a portion of it carried back to its original position to take the place of the cicatricial tissue at angle of nose, which was removed to make room for it.

After several days had elapsed and it had been demonstrated that the new material was receiving ample nutrition for its support from the nose itself, its upper edge was pared and carefully adopted to the upper portion of the nose stump which had necessarily been previously overlapped by the whole thickness of the cheek flap. This was stitched with silk and dressed under the

most careful antiseptic precautions. In some way my patient at this time contracted a severe cold, had high fever and was greatly prostrated for three or four days. On the fourth day dressings were removed and primary union had taken place at the central and most important portion; but on each side for a short distance it had failed to do so. These small wounds healed, however, very quickly by granulation, with scars invisible except by close scrutiny. Several minor operations were done subsequently in way of ornamentation and we had a nose which, while not as comely as nature's own, was still a fair substitute for the original. My patient was ordered to take iodide of potash occasionally during the remainder of her lifetime. No tendency to a recurrence of the old trouble has appeared since the operation, now over two years.

CASE OF METACARPAL FRACTURE AND DISLOCATION.

BY A. HAMILTON DEEKENS,

RESIDENT PHYSICIAN, ST. MARY'S HOSPITAL.

The two following cases which I saw during my term in St. Mary's Hospital Dispensary last summer, are, I think, from their comparative rarity, worthy of mention in your journal.

Case I.—Geo. F., 25 years old, came in one Sunday morning complaining of a sore and stiff thumb received during a fight the previous evening. Examination showed a complete forward dislocation of the proximal phalanx of the thumb. The symptoms were typical of the displacement, viz., pronounced shortening, dorsal and palmar prominence (also dorsal convexity below the prominence), and the thumb projected slightly outward, and was fixed. Reduction was effected without ether by means of forced traction, using the ordinary clove-hitch knot, at the same time making pressure upward and outward on the palmar projection, a sudden flexion inward bringing the two bones into correct apposition. A binders' board dressing, with firm bandaging, and soothing lotions for the following day or so, was the treatment adopted, and satisfactory results followed. Agnew speaks of this dislocation being quite a rare one.

Case II.—Chas. H., 17 years old, came to Dispensary complaining of a sore hand, received in a fall a few days previously. Ex-

amination showed a fracture of the second metacarpal bone about the centre. The boy said that in falling his hand struck a rail which was lying in a slanting direction and then slid down it to the ground.

Agnew mentions having never seen this particular fracture alone, although Hamilton mentions six in an analysis of fourteen metacarpal fractures. The hand was dressed with broad palmar splint, well padded to preserve the palmar concavity, with small pasteboard splint posteriorly, directly over the injured bone. Good results followed.

EMBOLISM OF SUPERIOR MESENTERIC ARTERY.

BY J. H. STUBBS, M. D.,
LONDON GROVE, PA.

Having been benefited by the recorded experience of others, in rare and interesting cases, I am led to report the following, which occurred in my practice:

Wm. M., twenty years old, consulted me Aug. 15, 1889, complaining of pain in the abdomen, of about three hours' duration. Neither pulse nor temperature were abnormal, and his bowels had been moved twenty-four hours before. The day previous to the attack he had eaten corn and blackberries. Thinking the pain was perhaps due to colic, I gave him a cathartic and one drachm of camph. tinct. opii., directing him to keep quiet and take a light diet for the day. He returned at mid-day saying his pain had not abated but during the last hour had greatly increased. His distressed countenance and bent position confirmed the statement. I now put him on his back and carefully examined the abdomen with negative results. I could manipulate the abdomen without producing any additional pain, or eliciting tenderness. There was no tumor or tympanitis, the pain was referred to the umbilical region, was intense. I gave him a dose of morphia which was soon rejected. The patient now assumed all positions, rolling on the floor or walking to and fro. Morphia was given hypodermically, and continued in large doses with as little effect as I have ever seen from so extensive an administration. He was not able to be taken home until about nine o'clock that evening. The next day found him more comfortable—doubtless the result of the anodyne taken during the night. His bowels not having

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been moved, I repeated the cathartic. Toward evening the pain increased again. The abdomen became intensely tender; could not bear the weight of the bed-clothing. The patient wanted water, but it nauseated him. During the night the egesta became stercoraceous. I saw him early on the morning of the following day. He had a bad night with no sleep and was pale, his entire body bathed in a clammy perspiration, his nose pinched, his eyes sunken and great prostration very apparent. He still begged for relief from his suffering. There having been no action from the bowels, I administered a clyster—first giving a stimulant, but although I remained some time to see if we would have any response, no movement was obtained. In half an hour after my return home I was summoned, the messenger informing me that the patient was dead. His attendant had been absent from the room about fifteen minutes, when he returned he found the patient lying on the floor dead. He had been up to the commode, his bowels had been evacuated; the stool contained the corn and seeds taken the day before his illness. I never saw a cadaver so markedly cynosed, save one who died from rupture of the stomach, produced by a blow. The body was as dark as a negro: I presume the effort of getting up and the sudden change of position produced heart failure.

Autopsy, assisted by Dr. Gifford, fourteen hours after death: Rigor mortis marked; surface of entire body dark; abdomen somewhat distended. In the abdominal cavity was a large quantity of sero-sanguinolent fluid, containing a large quantity of lymph flakes. The peritoneum and omentum had largely disappeared from suppurative inflammation; there were many bands of lymph uniting the folds of the bowels in many places. There was no occlusion of the bowels. The liver, kidneys, and spleen were normal. The small intestines were intensely hyperemic, in some places almost gangrenous. The mesenteric glands of the small intestines were enlarged, and in the mesentery was a small, dark tumor, which on examination proved to be an embolism of the superior mesenteric artery. Owing to the large size of the vessel occluded and the absence of sufficient arterial anastomosis, the hemorrhagic infarct was large and consequently the area of collateral hyperemia was extensive. If there had been no *post-mortem* examination in this case, the

cause of death could not have been surmised, but a diagnosis of obstruction or strangulation of the bowels, which the symptoms so clearly resembled, would have been reached. I have not in any of the text books or journals seen a similar case reported.

SOCIETY REPORTS.

NEW YORK ACADEMY OF MEDICINE. SECTION ON ORTHOPÆDIC SURGERY.

Stated Meeting, October 23, 1889.

DR. A. B. JUDSON in the Chair.

DR. H. W. BERG read a paper on

Rachitic Pseudo-Paralysis,

and stated that in this affection the rickety child from two to five years old is unable to walk, and in some cases he cannot stand or even sit. The disability is not the result of nervous lesion, but rather the result of muscular weakness, pain in the muscles and in the bones at the points of muscular attachment, flaccidity of the ligaments, and softness of the bony levers. Such a child wishes to be let alone; he instinctively prefers to keep quiet. This condition is to be distinguished from infantile paralysis by the absence of local atrophy and cold, and real paralysis not so readily, however, from post-diphtheritic paralysis, where the differential diagnosis will rest on the preceding occurrence of diphtheria, the recent origin of the paralysis, and, above all, on the difficulty of swallowing and speaking dependent on involvement of naso-pharyngeal and laryngeal muscles. Spastic paralysis even when mild has an exalted muscular activity which serves to distinguish it from rachitic pseudo-paralysis; and the paraplegia of Pott's disease cannot be mistaken if the kyphosis is obvious. The prognosis is uniformly favorable. These are the cases which give such good results after indiscriminate circumcision. The object of treatment should be to counteract the effect of rachitic malnutrition. These children should have a great deal of milk; cod-liver oil should be given unmixed; and phosphorus in the following prescription:

R Phosphori gr. j
 Alcohol. absolut. ℥ cccl
 Spt. menth. pip. ℥ x
 Glycerinæ fʒij

M. et Sig. Six minims t i. d. to be increased one drop until ten drops are given.

DR. W. L. CARR said that he had seen a number of cases in which a striking lack of muscular power was symptomatic of rickets, although bone changes were not obvious. A number of these children had been fed at the table or on patented foods. Proper attention to diet soon brings about a restoration of muscular power without tonics.

DR. R. J. DEVLIN recalled well marked cases of this affection in children who had been exclusively fed on milk from a healthy mother.

Nervous Symptoms produced by Phimosis.

DR. T. H. HOLGATE said that in his experience with non-rickety children the relief of preputial irritation by discriminating operative interference had removed serious nervous troubles. In one case, which he had presented to the Academy, inability to walk or stand had been relieved in this way in a child who was entirely free from evidences of rickets.

DR. R. H. SAYRE related a similar case of a boy, who from some central lesion, had not walked for some years. After partial circumcision he could walk with the aid of two canes. A trouble of twelve years' standing had thus been relieved in six weeks.

DR. BERG in closing the discussion, said that he agreed with Dr. Carr in thinking that rachitic inability to walk is sometimes present without the usual rachitic deformities. He recognized the fact that urinary troubles occur as the result of contracted prepuce, but he had never seen a case of lesion of the nervous centres cured by circumcision. He recalled a case of difficult micturition and inability to walk in a rickety child whose phimosis was not relieved because the operation was refused. The difficulty in micturition persisted, but the child walked within eight weeks after being put upon proper diet.

Excision of Hip-Joint.

DR. R. H. SAYRE presented a little boy on whom Dr. L. H. Sayre had operated by excision of the hip-joint. About a year ago the patient had presented himself with the hip very badly deformed from long-standing disease. The thigh was flexed on the trunk

at a right angle, and abducted. A deep abscess was opened behind the trochanter and the acetabulum and femoral head were then found to be badly eroded. The femur was divided above the lesser trochanter, at right angles with the axis of the shaft, and the deformity was thus reduced by excision instead of by simple tenotomy which had been proposed at first. The wound was stuffed with iodoform gauze and after two months of the wire cuirass, a long traction splint was applied and the boy took a long journey to his home. At the present time there is no abduction, and but a trace of flexion with some motion in the joint.

Treatment of Abscesses.

DR. JOHN RIDLON asked whether an operation would have been advised for the abscess alone. He had found that many abscesses are certain to disappear when the hip is properly treated mechanically.

DR. SAYRE said that as the abscess was causing but little disturbance, he would have postponed operating on it if the child could have been kept under observation.

DR. JUDSON thought that opening an abscess, if done at all, should as a rule be followed by excision, as in the case related by Dr. Sayre, on the ground that the presence of diseased bone is a greater evil than the presence of pus. He had seen no bad results follow letting the abscesses alone.

DR. A. M. PHELPS said that there were some cases of abscess which he would probably not open at once, but he believed the operation perfectly harmless and desired to speak emphatically against the opinion that it is a dreadful and a dangerous thing to open these abscesses.

DR. H. L. TAYLOR thought that if rest and protection are secured for the joint, the occurrence of abscesses is not of serious import. The aspirator had failed in his hands apparently because it leaves shreds of necrotic tissue which prevent the abscess from closing. It seems wise in most cases to open freely, clean out easily removable debris, and close the wound. If sinuses remain, injections with a saturated solution of iodoform in ether will sometimes cause them to close.

DR. L. A. SAYRE said that on the principle that an empty house is better than a bad tenant, he always evacuates an abscess as soon as found, and by doing this antiseptically, and securing thorough drainage, there is no danger of bad results.

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DR. R. T. MORRIS said his usual custom is to open these abscesses at once, washing out with peroxide of hydrogen, removing debris, and establishing drainage. He related a recent case in which this procedure, followed by traction in the line of the deformity, had secured a good result. He had recently performed excision in another case in which disease of the acetabulum and femur had been produced by the application by the physician in attendance of traction in a straight line, according to Thomas's method. In excising the hip, he usually makes a section through the great trochanter in such a way as to allow the lesser trochanter to go into the acetabulum and so prevent the formation of a flail joint.

Thomas's Splint.

DR. PHELPS said that Mr. Thomas would treat a case when the leg is flexed at right angles, by lashing the patient to the splint, and then with his wrench bending the splint down as nearly as possible to a straight line. That is a form of traction which produces great intra-articular pressure and would, if continued for any length of time, produce destruction of the joint.

DR. RIDLON said that he had used Thomas's hip splint in some twelve or fifteen cases with great satisfaction. He found it cheap and easily applied. It had not caused destruction of tissue, but, on the contrary, had relieved symptoms and promoted recovery.

DR. L. A. SAYRE said it seemed as if the profession were determined to misunderstand him, for he had endeavored for years past to make clear what he meant by traction in the line of the deformed limb: it is to make traction in such a way as to separate slightly the bone from the base of the acetabulum, and so prevent pressure, gradually changing the line of traction until the limb is brought parallel with the other limb, and then apply the splint; whereas, if one employed leverage, as Thomas does, this pressure in the joint is only increased. Not until the limb is in proper position can the splint be applied to advantage. One objection to Thomas's splint is that there is no traction for overcoming muscular rigidity, and hence, it seems to be fixation only, and as such does not compare in point of efficiency with a properly applied plaster of Paris splint; for, here the weight of the limb will produce some traction, and the plaster of Paris gives the necessary fixation. Another ob-

jection is that the patients wearing Thomas's splint cannot sit down, whereas with a properly applied splint they can sit down with great comfort.

The Question of Excision.

DR. R. H. SAYRE said that in the case presented the original intention had been simply to open and drain the abscess; but the diseased condition of the bones necessitated excision. As regards the condition under which he would advise excision, if the leg were straight and the abscess causing but little disturbance, he would postpone the operation, provided the patient could be kept under observation; but if the latter condition could not be secured, he would be disposed to remove whatever disease already existed rather than allow the case to go from under observation with the disease ready to extend at any time.

DR. BERG thought the good condition of the patient in the present case justified operative procedure for the correction of deformity.

DR. TAYLOR thought that excision might be required in neglected cases, of which there probably always will be a considerable number; but the operation should be looked upon rather as treatment of the results of neglect than as treatment for hip disease.

DR. PHELPS practiced excision by an open wound, leaving the periosteum to reproduce bone. The German surgeons remove the periosteum and capsule and try to secure union by first intention. Their results are shortening, flail joints, and relapses in a large per cent. of cases. He related two recent cases of excision in patients thirty-four and twenty-three years of age. In these cases the femoral head was destroyed and the acetabulum extensively diseased, a condition in which removal of the disease is the most rational treatment. In one of the cases, the head was found separate from the shaft. He had frequently found this condition, and believed that the head lying loose in the joint cavity is to be considered as a foreign body. It is better to remove it than to leave it to undergo decomposition and lead to septicæmia and amyloid disease. In general, he thought excision under the age of ten is a calamity. In the case presented, however, he thought the result was good, as extreme deformity had been corrected.

DR. JUDSON thought that in excision we have no certainty of removing, together

with the diseased bone, those portions which contain latent foci. He had found no method of determining whether the focus which has burst into inflammation is the only outbreak to be feared, or whether it is to be followed by others. In some patients a single abscess closes the morbid process; in others, one abscess follows another, showing that osteitis is lighted up successively in the neck, the head, the shaft, and the bones of the pelvis. An excision may fortunately remove all that is diseased, with a good immediate result; or it may leave dormant foci which come into activity one after another, and lead to a tedious and unfavorable result. Ultimate good results are obtained in these difficult cases by management with the hip splint, and without excision.

PERISCOPE.

The Treatment of Sciatica.

It is essential in every case of sciatica to prescribe complete rest of the limb, and most cases, if treated in this way, with the addition of hot linseed-meal poultices along the affected nerve, will soon get well. In the gouty habit, it is also advisable to order saline purgatives and iodide of potassium in five-grain doses, together with a similar amount of antifebrin. Hypodermic injection of morphia or cocain will often give relief to the pain, but have no curative tendency. If there be fulness at any part of the nerve, acupuncture or leeching may be tried; and, failing these, massage and electricity may be used. Galvanism should be used while pain exists, and in the way recommended by Dr. Steavenson, who applies a wet pad, of metal and amadou, connected with the positive pole, over the abdomen, and moves a carbon disc electrode connected with the negative pole gently up and down over the course of the sciatic nerve. Dr. Eccles thinks it not unreasonable to suppose that much of the acute suffering in sciatica is due to the pressure of the abnormally increased fluid within the nerve sheath upon the nervi nervorum; and he suggests that the degeneration of the nerve fibres is due in many cases to the interference with their nutrition by the oedema within and the stagnation without the affected nerve sheath. This theory offers an explanation of the good results which often follow acupuncture, leeching, or massage. Nerve

stretching should only be employed as a *dernier ressort*; its chief value probably consists in the release of the nerve from adhesion.—*Medical Chronicle*, Jan., 1890.

London Physicians on the Treatment of La Grippe.

A young lady reporter of the *Pall Mall Gazette* visited several leading London physicians on Jan. 7, and secured prescriptions from them in anticipation of getting the influenza. She told Sir Oscar Clayton she had a sister suffering from it, and felt like getting it. The physician wrote for her the following prescription, assuring her, in answer to her question, that it would do for anybody who has influenza:

R Ammon. sesquicarb. f 3j
Potass. bicarb. 3j
Tinc. aurantii f 3iv
Aque puræ ad. f 3 viij
" flor. aurant. f 3 iij

"You will take this three times a day," said Sir Oscar, "in a tablespoonful of lemon juice. If I were you I should eat two oranges a day. Oranges are an excellent thing in influenza. They keep it from the chest. A very good thing indeed. You may have a little fish or chicken; and have two glasses of port-wine a day made into negus. Take plenty of strengthening food—sago or tapioca pudding. Put your feet in warm water every night, with a teaspoonful of mustard."

Sir Morell Mackenzie advised his patient to go home and get to bed if she felt bad, and he gave her the following prescription:

I.
R Potass. nit. 3j
Sp. ether. nit. f 3iv
Liquor ammon. acet. f 3 iss
Aque ad. f 3vj

II.
R Tr. quinae. One teaspoonful in a wine-glass of water, twice daily, before meals.

"You will," he said, "take this for four days. No. 2 is a little tonic to take when you get better. No doubt if you are a victim you'll feel a little weak for some time."

"Yes; and about diet?"

"Well, plenty of beef-tea and some milk, and there can be no objection to a little fruit."

Dr. Robson Roose told her he was attend-

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ing sixty patients at present—from Cabinet Ministers downwards. Recommending her not to alarm herself, Dr. Roose wrote the following for a mixture to ward off the disease:

R Quinæ disulph. grs. xij
 Pot bromid. ʒ iss
 Acid. hydrobromic. dil. . . . f ʒ iss
 Tr. aurant. f ʒ ss
 Aquæ ad. f ʒ viij
 The eighth part (two tablespoonfuls) twice a day.

The Late Epidemic of Dengue Fever at Smyrna.

The *Lancet*, Jan. 4, 1890, contains the report of the Medical Committee appointed to inquire into the epidemic dengue fever. The symptoms and treatment of the disease are described as follows:

In the great majority of cases the onset of this fever is sudden, without any premonitory symptoms; in a few cases, however, a feeling of malaise lasting twenty-four to forty-eight hours precedes the attack. Ordinarily an individual in good health suddenly has a shivering fit, followed by violent fever and intense headache, the thermometer registering 104° to 105.8° F., the pulse 100 to 120, the face flushed, the eyes blood-shot and painful, with nasal catarrh and sore throat, and the tongue large and furred. Nausea and vomiting are common, and sometimes vertigo and delirium. Fainting occurs in old people and hysterical women, whilst præcordial oppression is a frequent symptom. The patient complains of sharp pains shooting over the body, but especially down the back and lower limbs; there is also a general feeling of soreness and great mental and bodily lassitude. An eruption resembling that of scarlatina appears at the same time but is occasionally like erysipelas or urticaria; it is situated on the face, the dorsal surface of the hands and the chest usually, but may cover the entire body. The urine is abundant and clear as a rule, though rarely it is scanty and high colored. No albumin is found, except in cases with renal complications. Constipation is the rule, but diarrhœa occurs, especially when the patient has used purgatives too freely in the early stages. There is a great liability to epistaxis, hæmatemesis, metrorrhagia, and hæmaturia, this hemorrhagic tendency being very frequent and remarkable in the epidemic in Smyrna.

The initial fever lasts twenty-four to thirty-six hours, and is accompanied by profuse sweating, the perspiration sometimes having a characteristic odor. On the decline of the fever the eruption fades, the pains in the limbs abate and a remission occurs, lasting ordinarily from two to three days; then the fever returns accompanied by a second eruption more confluent, of wider extent and better marked than the first. This eruption lasts several days, even after the disappearance of the fever. There is intolerable itching, followed by desquamation analogous to that of the eruptive fevers. There are cases in which the eruption is entirely absent. During this period some patients complain of acute pains in the smaller joints, and there may be swelling of the hands. In grave cases the initial fever remains for three or four days at about 104° to 105.8° F. The sweating is absent and the eruption slow in appearing. When the fever is prolonged it is noticed that the pulse is not in keeping with the temperature, being too slow, and this characteristic continues during convalescence. Convalescence commences with the cessation of the fever after the second eruption; there is marked loss of appetite, attacks of giddiness, and stiffness of the limbs, in fact patients appear to be recovering from a long and severe illness. Its duration is usually long. It is often observed that an exposure to cold, violent exercise, or errors in diet lead to a fresh attack of fever accompanied by vomiting. Such, in brief, are the clinical features of this disease, the diagnosis of which can only be uncertain at the commencement of the epidemic, for its symptoms so distinguish it from intermittent and eruptive fevers as to leave no room for doubt. Age, sex, and social position do not influence dengue fever, which attacks all classes impartially and spreads with remarkable rapidity. It is estimated that four-fifths of the inhabitants of the town of Smyrna (150,000) were attacked in three months. The prognosis is favorable, being worse among infants and old people and those who are debilitated from any cause. A dozen deaths occurring out of 100,000 cases testify to the benignity of the malady. It is from the complications that the danger of dengue fever arises, the most common being bronchitis, catarrhal pneumonia, uncontrollable vomiting, diarrhœa, intestinal, bronchial, uterine, or vesical hemorrhages. Two cases of myelitis have been observed,

and in one case a pseudo-membranous laryngitis necessitated tracheotomy. Convulsions are common in the early stages in very young children.

The treatment must be: first, to assist the appearance of the eruption; secondly, to attend to the pressing symptoms and complications; and thirdly, to keep up the strength during convalescence. Saline purgatives are useful at first, but must be used with care. Sudorifics generally are indicated. Antipyrin as an analgésic and sudorific has been very advantageously employed; salicylate of soda gives great relief to the pains in the joints, and bromide of potassium has been found of use in nervous troubles. In cases where neither the salicylate of soda nor antipyrin succeeds in subduing the pains, much relief may be got by hypodermic injections of morphia, which also is of undoubted use in checking the sickness. Sulphate of quinine appears only to increase the susceptibility of the gastric mucous membrane. Those complications which are grave each requires its peculiar treatment; but it must be remembered that certain of them, such as hemoptysis, slight hematuria, and exaggerated reflex phenomena, disappear by themselves at the decline of the fever. The diet should be milk and beef-tea with warm drinks during the fever; there are cases, however, in which iced drinks are more suited to soothe the irritability of the stomach. Finally, bitters and tonics may be given during convalescence.

Nitrate of Amyl in Epilepsy.

The following interesting case is reported by Dr. J. E. Engstad, in the *Northwestern Lancet*, for Jan. 15, 1890:

Some time ago, a ten-year-old girl was brought to my office in a state of epileptic convulsion. Her father stated that she had an attack about once a week, and that the convulsive, or second stage, lasted from a few minutes to hours.

She was on a visit in town and had an attack while out walking, "seeing the sights." Any excitement or undue exertion was liable to precipitate an attack. She first suffered from an attack when about three years old, the disease having increased in severity every year. All remedies usually recommended had been given a trial, without any appreciable benefit.

I ordered nitrite of amyl pearls, and ex-

plained their use. The pearls were not to be obtained in our city that day, so the druggist substituted nitrite of amyl in bulk, and explained to the father to use one or two drops on a handkerchief for inhalation, instead of a pearl, but the stupid old fellow thought that a rather visionary treatment, and so he gave her, the first time the premonitory symptoms manifested themselves, about one-half a teaspoonful of the amyl nitrite. The poor sufferer had hardly swallowed the dose before her face became purple, eyes staring and general appearance indicating intense suffering. After a short time she became a raving maniac, and had to be restrained to prevent doing herself severe injury. After about ten hours she became calmer and fell into a sleep, or probably a stupor, that lasted until the next day, when she awoke perfectly well.

She has not had a single attack since. That the dose did not instantly kill her has been a mystery to me.

The enormous dose probably produced a nervous impression that effectually eradicated the neurotic disturbance.

Cholera Morbus.

The following formula for cholera morbus, colics, etc., is claimed to be most efficacious:

R. Spts. ether, comp.,
Spirit ammoniac aromat.,
M. Chloroformi, aa q s.

Dose—Teaspoonful every half-hour, or every hour, as occasion demands, until relieved. The first dose will usually suffice.

Primary Actinomycosis of the Lungs.

Dr. Lindt, of Königsberg, has reported, in the *Lancet*, Jan. 11, 1890, a case of actinomycosis of the apices of both lungs from the clinic of Professor Lichtheim. The patient, a woman, had had pulmonary symptoms for several months before contracting a severe cough, which induced her to apply at the clinic. The sputa were examined for bacilli, but none were found. An abscess developed in the neck, which was supposed to be connected with the cervical vertebrae. In the course of changing the dressings of this abscess there were discovered in the pus a number of small bodies of about the size of the head of a pin, which set the diagnosis

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at rest. These bodies were made up of ray-fungus. It was afterward discovered that the abscess was not connected with the vertebrae, but had its relations through and among the muscles of the neck. Death took place after four months.

The Treatment of the So-called Influenza.

After an extensive experience with the epidemic, Dr. Illingsworth, in the *Med. Press and Circular*, Jan. 15, 1890, claims to have found that an attack may always be cut short in a day by the following mixture:

R	Liquor ferri perchlor. fort.	. . . f 3 ss
	Spirit. etheris nitrosi	. . . f 3 ss
	Vin. ipecac.	. . . f 3 j
	Tinct. opii	. . . mxx
	Glycerin.	. . . f 3 ss
	Aq. ad	. . . f 3 vj
M. Sig.	One tablespoonful every two hours.	

The patient is left with a slight cough and weakness, curable by iron, sulphuric acid, and opium in ordinary doses.

Iodine as a Remedy for Vomiting.

M. Darthier (*L'Union Médicale*, Dec. 10) bears testimony to the value of tincture of iodine administered internally for the relief of vomiting, a remedy recommended by the late Professor Lasèque in the vomiting of pregnancy. The author had observed its use in nineteen cases, eleven of which were tubercular subjects, and found that it is of more value in the vomiting of early phthisis than in that of the later stages of this disease. At the same time he gives instances of advanced cases with obstinate vomiting where the symptom was largely controlled by the drug. Amongst other cases he gives one of bronchial dilatation (subsequently fatal from acute tuberculosis) in a female, who for three weeks had regularly vomited after every meal. From the date of commencement of the use of the drug she ceased to vomit, and after a week's treatment, which was not productive of any signs of iodism, was completely cured of the symptom. Apart from phthisical vomiting, M. Darthier finds it useful in alcoholic gastritis, in ulcer of the stomach, and in the vomiting of pregnancy and of chlorosis, instances of which are recorded. He says that the majority of the patients take the iodine with

pleasure; it often produces an agreeable sense of warmth in the stomach, lasting from five to twenty minutes. The dose is ten drops, dissolved in 125 grammes of water, taken in three portions immediately after meals. In a certain number of cases, symptoms of iodism are produced, chiefly coryza; but a good many patients do not experience any such inconvenience from it.—*Lancet*, Jan. 18, 1890.

Tracheal and Bronchial Stenosis.

Dr. Landgraf brought this subject under the notice of the Society of Medicine of Berlin at a recent meeting. The symptoms were so characteristic that a correct diagnosis was not difficult. Tracheoscopy would assist in localizing the seat of the obstruction, but a case might occur where there were two sites, and the symptom elicited at the seat of the minor obstruction might mask the presence of the major. He had had a patient under treatment, 45 years of age, who had contracted syphilis at the age of 25. In 1870 he lost a leg below the knee, married, and had four healthy children. In 1880, after having shown symptoms of syphilis, he became hoarse and had suffocating attacks, in the course of which he was tracheotomized. After he had worn the canula a long time, in order to get rid of it, he entered the Charité Hospital of Berlin. Laryngoscopic examination showed that the epiglottis was attached to the posterior of the fauces. The vocal cords formed an acute angle, a grayish red mass was visible in the triangular space. The patient died, and the autopsy showed an annular stricture reaching from the cords to the first tracheal ring. Half of the cricoid cartilage was absent. In the lower part of the trachea and in the bronchi were cicatricial ulcers, in right bronchus was a fetid piece of cartilage, plainly the missing half of the cricoid.

Struma was a prominent cause of stenosis. Gottres compressed the trachea, while new growths broke through it. The diagnosis was more difficult when tumors formed by the mediastinal glands were the cause. A case of this kind occurred in a soldier, who was admitted into hospital with symptoms of laryngeal and bronchial catarrh. The left supra-clavicular glands were enlarged, then the left inguinal glands became so, and after a period of comparative health, suffocative attacks came on. The presence of the en-

larged glands gave the clue to the correct diagnosis. According to military statistics, and his own observation, mediastinal tumors more frequently led to compression of the trachea than was believed generally. Other causes were aneurism of the aorta, diseases of the pericardium, the sternum, the vertebral column, syphilis, etc. Hysteria might lead to the symptoms of stenosis, as in the case of a man who presented the typical signs of it. Sounds were introduced into the trachea and bronchi, nothing was found and the man recovered after four applications of the instrument. There had been no return of the tracheal trouble.—*Med. Press and Circular*, Jan. 15, 1890.

Waxy Concretions in the Ear.

The following formula is proposed in *La Clinique* for a preparation to aid in removing accumulations of wax in the external auditory meatus:

Boric acid	1 dram.
Glycerin	1 1/2 fl. ozs.
Distilled water	1 1/2 fl. ozs.

This should be warmed and instilled into the ear, leaving it there for a quarter of an hour, repeating the process daily for several days. The result is to soften the plugs and make their removal comparatively easy by means of the syringe.—*Druggist's Circular*, February, 1890.

Traumatic Iridodialysis.

Cases of the above-mentioned trouble are sufficiently rare to warrant the presentation of the notes of a case recently under the care of Dr. John C. Bowker, and reported in the *Medical Record*, Jan. 25, 1890. The patient, a highly intelligent lad of eight years, was playing with his comrades when he felt something strike his left eye, followed by a sharp pain. He was immediately seen by a physician, who prescribed for him and sent him home. Two days later the father took the case into his own hands and, in examining the eye, found a leaden bullet, weighing eight and a half grains, snugly packed away between the ocular and palpebral conjunctivæ, at the external canthus. This was removed, and when the boy was brought to me there was but a slight conjunctivitis, ciliary

injection, and photophobia, together with a rent in the iris, covering probably five or six square millimetres, through which the red reflex was visible. The rupture was at the inferior external quadrant and about two millimetres of the ragged edge of the iris remained along the ciliary margin. The contraction of the iris threw the normal pupil into an irregular oval shape. Vision in the affected eye was 0.6, but through the artificial pupil light alone was distinguishable. The cornea was entirely uninjured and no abrasion could be detected even with a high-power lens. Though the false pupil still exists, the troublesome symptoms have, under treatment, wholly disappeared. The fundus is normal, the capsule seems unaffected, and the lad suffers almost no inconvenience, save from the disfigurement, which is slight.

Infantile Colic.

The following prescription is recommended by Dr. Bedford Brown, in the *Canada Med. Record*, Feb., 1890:

R	Ol. terebinthinæ	f 3j
	Chloroformi	gtt. x.
	Sodæ bicarb.	gr. x.
	Mucilag. acaciæ ad	f 3ij.
M. S.	f 3j every two or three hours for a child six months old.	

Solvine.

Solvine is the name of a new substance formed by mixing sulphuric acid and castor-oil, removing the excess of acid, dissolving the residue in water, and treating a precipitate, which gradually falls, with a mineral acid. The resultant liquid is of a clear yellow color and of an oleaginous consistence. The substance possesses very marked solvent properties, and passes readily through animal and vegetable membranes, being therefore absorbable by the skin. It is said to dissolve the red blood-globules when injected hypodermically, and is thus not to be regarded as a very safe substance for use in ointments. Indeed very pronounced toxic symptoms are reported to have followed the application of a solution of naphthol and solvine to the mucous membrane. Berlioz, who presented the substance at a recent meeting of the Therapeutical Society, in Paris, proposed to call it sulphuricinic acid.—*Medical Record*, Feb. 1, 1890.

THE MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

CHARLES W. DUILLES, M.D.,
EDITOR AND PUBLISHER.

N. E. Cor. 13th and Walnut Streets,
P. O. Box 843. Philadelphia, Pa.

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HYDERABAD CHLOROFORM COMMISSION.

One of the most important and satisfactory series of investigations in the province of medicine, is that which has recently been completed by the Hyderabad Chloroform Commission. The Commission owed its existence to Surgeon-Major Lawrie's veneration for his late teacher, Professor Syme, and his desire to prove the correctness of Syme's teaching that chloroform might be administered with perfect safety, provided that the administrator watched the respiration with sufficient care. Accordingly, some time ago, at Dr. Lawrie's suggestion, the Nizam's Government appointed a Commission, which conducted a series of experiments, and arrived at the conclusion that chloroform always arrests the respiration before the heart. But the facts brought for-

ward seemed insufficient to overthrow the conclusions of many observers both in Europe and elsewhere, whose researches seemed to prove that one of the dangers from chloroform was paralysis of the heart.

Dr. Lawrie, therefore, proposed a second commission, to which the London *Lancet* should send a representative, and for this purpose the Nizam's Government generously offered the sum of £1,000. As our readers already know, the *Lancet* selected Dr. Lauder Brunton, and, on his arrival at Hyderabad on Oct. 22, 1889, a second commission was immediately formed, consisting of Surgeon-Major Lawrie as President, and Drs. Lauder Brunton, Bomford and Rustomji as members. Their complete report appeared in the *Lancet* for Jan. 18, 1890.

The experiments were of two kinds, those of one group being made without recording apparatus, and being intended to ascertain what influence is exerted by various conditions upon the relation between the stoppage of heart and of respiration, and the limits within which artificial respiration and other means of resuscitation are useful. The second group consisted of experiments with recording apparatus, and were made for the purpose of ascertaining the effect of various conditions upon the heart and blood pressure. In the first group chloroform was given in all sorts of ways, alone or with morphine, atropine, and strychnine, to animals healthy and diseased, fasting or replete. The result was invariable: in every case the respiration stopped before the heart, sometimes a long time before it. But the effect of partial asphyxia in causing the heart to stop very soon after the respiration is deserving of particular notice.

The second group of experiments on heart and blood pressure was made with apparatus arranged in such a way that the whole experiment could be recorded from beginning to end in such a compass as to admit of photographic reproductions in its entirety. This was managed by recording the general blood pressure on a slowly revolving drum,

and taking at intervals a tracing on a second drum, revolving with sufficient rapidity to show each beat of the pulse. About one hundred and fifty experiments were made in this way, and the influence of everything that seemed likely to affect the blood pressure during chloroform narcosis was ascertained. Particular attention was directed to the production of shock or syncope, and to the effect of chloroform itself on the heart and blood-pressure in healthy animals, and also in cases where fatty degeneration of the heart and other organs had been produced by the previous administration of phosphorus. The results of these experiments were unexpected. It was found to be exceedingly difficult to affect the heart reflexly, and recourse was therefore had to direct stimulation of the vagus, by which the heart could be slowed or stopped completely. Instead of this causing the death of the animal, however, it appeared rather to be a safeguard, preventing the anæsthetic from being conveyed in too great quantities to the nerve centres.

In the *Lancet's* note to one of Dr. Brunton's telegrams, and referred to in the *REPORTER*, Jan. 4, 1890, the change which his views had undergone was called attention to. From the present report it may, however, be seen that the discrepancy between the views of different schools arises from the fact that sufficient consideration has not been given to the conditions under which the chloroform is given. Although it may paralyze the heart if applied directly to it, yet this condition does not occur in practice, for here it is neither applied to that organ nor yet is it blown forcibly into the lungs. It is inhaled by the patient, and when this is the case it stops the respiration before the heart. The practical outcome of the research would appear to be that deaths from chloroform are not inevitable. They are, therefore, preventable, and by due care in its administration they may be with certainty avoided. The conclusions of the Commission are sweeping, and without abundant

evidence cannot be accepted. Fortunately the generosity of the Nizam's Government has not been limited to the appointment and payment of the Commission, but by well-timed liberality it has secured the permanent utility of the work done by it, for it has had every tracing photographically reproduced, and will present a copy of the complete work to all the principal medical libraries throughout the world.

The following are the practical conclusions which the Commission think may fairly be deduced from the experiments recorded in their report:

I. The recumbent position on the back and absolute freedom of respiration are essential.

II. If during an operation the recumbent position on the back cannot, from any cause, be maintained during chloroform administration, the utmost attention to the respiration is necessary to prevent asphyxia or an overdose. If there is any doubt whatever about the state of respiration, the patient should be at once restored to the recumbent position on the back.

III. To ensure absolute freedom of respiration, tight clothing of every kind, either on the neck, chest or abdomen, is to be strictly avoided; and no assistants or bystanders should be allowed to exert pressure on any part of the patient's thorax or abdomen, even though the patient be struggling violently. If the struggling does occur, it is always possible to hold the patient down by pressure on the shoulders, pelvis, or legs without doing anything which can by any possibility interfere with the free movements of respiration.

IV. An apparatus is not essential, and ought not to be used, as, being made to fit the face, it must tend to produce a certain amount of asphyxia. Moreover, it is apt to take up part of the attention which is required elsewhere. In short, no matter how it is made, it introduces an element of danger into the administration. A convenient form of inhaler is an open cone or

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V. At the commencement of inhalation care should be taken, by not holding the cap too close over the mouth and nose, to avoid exciting, struggling, or holding the breath. If struggling or holding the breath do occur, great care is necessary to avoid an over-dose during the deep inspirations which follow. When quiet breathing is ensured as the patient begins to go over, there is no reason why the inhaler should not be applied close to the face; and all that is then necessary is to watch the cornea and to see that the respiration is not interfered with.

VI. In children, crying ensures free admission of chloroform into the lungs; but as struggling and holding the breath can hardly be avoided, and one or two whiffs of chloroform may be sufficient to produce complete insensibility, children should always be allowed to inhale a little fresh air during the first deep inspirations which follow. In any struggling persons, but especially in children, it is essential to remove the inhaler after the first or second deep inspiration, as enough chloroform may have been inhaled to produce deep anæsthesia, and this may only appear, or may deepen, after the chloroform is stopped. Struggling is best avoided in adults by making them blow out hard after each inspiration during the inhalation.

VII. The patient is, as a rule, anæsthetized and ready for the operation to be commenced when unconscious winking is no longer produced by touching the surface of the eye with the tip of the finger. The anæsthetic should never under any circumstances be pushed till the respiration stops; but when once the cornea is insensitive, the patient should be kept gently under by occasional inhalations, and not be allowed to come out and renew the stage of struggling and resistance.

VIII. As a rule, no operation should be commenced until the patient is fully under

the influence of the anæsthetic, so as to avoid all chance of death from surgical shock or fright.

IX. The administrator should be guided as to the effect entirely by the respiration. His only object, while producing anæsthesia, is to see that the respiration is not interfered with.

X. If possible, the patient's chest and abdomen should be exposed during chloroform inhalation, so that the respiratory movements can be seen by the administrator. If anything interferes with the respiration in any way, however slightly, even if this occurs at the very commencement of the administration, if breath is held, or if there is stertor, the inhalation should be stopped until the breathing is natural again. This may sometimes create delay and inconvenience with inexperienced administrators, but experience will make any administrator so familiar with the respiratory functions under chloroform that he will in a short time know almost by intuition whether anything is going wrong, and be able to put it right without delay before any danger arises.

XI. If the breathing becomes embarrassed, the lower jaw should be pulled, or pushed from behind the angles, forward, so that the lower teeth protrude in front of the upper. This raises the epiglottis and frees the larynx. At the same time it is well to assist the respiration artificially until the embarrassment passes off.

XII. If by any accident the respiration stops, artificial respiration should be commenced at once, while an assistant lowers the head and draws forward the tongue with catch-forceps, by Howard's method, assisted by compression and relaxation of the thoracic walls. Artificial respiration should be continued until there is no doubt whatever that natural respiration is completely re-established.

XIII. A small dose of morphia may be injected subcutaneously before chloroform inhalation, as it helps to keep the patient in a state of anæsthesia in prolonged opera-

tions. There is nothing to show that atropine does any good in connection with the administration of chloroform, and it may do a very great deal of harm.

XIV. Alcohol may be given with advantage before operations under chloroform, provided it does not cause excitement, and merely has the effect of giving a patient confidence and steadying the circulation.

The Commission has no doubt whatever that, if the above rules be followed, chloroform may be given in any case requiring an operation with perfect ease and absolute safety so as to do good without the risk of evil.

NOTES AND COMMENTS.

A Curious Hypnotic Test.

Dr. J. M. Charcot writes in the *January Forum*:

"The end I have ever held before my eyes, then, and which I hope I have never lost from view, is this: To study the hypnotic phenomena according to a strictly scientific method, and for this purpose to employ processes, purely physical and which can always be compared with one another, so that the results obtained by me may be rigorously tested by all observers who shall use the same processes under the same conditions.

"Take one example from among a thousand. I present to a woman patient in the hypnotic state a blank leaf of paper and say to her: 'Here is my portrait; what do you think of it? Is it a good likeness?' After a few moments' hesitation, she answers: 'Yes, indeed, your photograph; will you give it to me?' To impress deeply in the mind of the subject this imaginary portrait, I point with my finger toward one of the four sides of the square leaf of paper, and tell her that my profile looks in that direction; I describe my clothing. The image being now fixed in her mind I take that leaf of paper and mix it with a score of other leaves precisely like it. I then hand the whole pack to the patient, bidding her to go over them and let me know whether she finds among these anything she has seen before. She begins to look at the leaves one after another, and as soon as her eyes fall upon the one first shown to her (I had made

upon it a mark that she could not discern), forthwith she exclaims: 'Look, your portrait!' What is more curious still, if I turn the leaf upside down, as soon as her eyes rest upon it she turns it over, saying that my photograph is on the obverse. I then convey to her the order that she shall continue to see the portrait on the blank paper even after the hypnosis has passed. Then I awaken her and again hand to her the pack of papers, requesting her to look over them. She handles them just as before when she was hypnotized, and utters the same exclamation: 'Look, your portrait!' If now I tell her she may retire she returns to her dormitory, and her first care will be to show to her companions the photograph I have given her. Of course, her companions, not having received the suggestion, will see only a blank leaf of paper without any trace whatever of a portrait; and will laugh at our subject and treat her as a visionary. Furthermore, this suggestion, this hallucination, will, if I wish, continue several days; all I have to do is to express the wish to the patient before awakening her.

"The foregoing experiments have been made hundreds of times by me and by others, and the fact can easily be substantiated; their objectivity is as complete as could be wished in researches of this kind. Hypnotism is directly amenable to our means of investigation, and must needs be an integral part of the known domain of science. To that goal our efforts ought to be directed." —*Boston Med. and Surg. Journal*, Jan. 23, 1890.

Blood Poisoning from a Glove.

A somewhat sensational paragraph has appeared in a London lay paper relating to the death of a lady which is said to have been due to blood poisoning derived from a glove. The facts, as stated, are as follows: A young Jewess from Kieff was visiting her friends in the Polish capital, who, in honor of her visit, gave a large ball. The young lady, well known for her beauty and other attractions, purchased for the occasion a pair of long Danish gloves. While in the middle of a dance she suddenly felt a severe pain in her left wrist, which rapidly became inflamed and swollen. Upon reflection she remembered to have slightly pricked the wrist with a pin while making her toilet. Subsequently medical examination showed that the young lady was suffering from car-

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buncle and blood poisoning, contracted from the glove. The medical men in attendance expressed their conviction that the glove had been made from the skin of an animal suffering from anthrax. Within forty-eight hours their unfortunate patient was dead. The rapidity of the development of the symptoms is not the least remarkable feature in this case; we do not question the theory which has been advanced to account for the attack; it is a quite possible one, though without corroborative evidence it sounds just a little transcendental. In view of the process through which "skins" have to pass before being cut up into gloves, a perfectly disinterested person can only feel some admiration for the robustness of the individual microbes whose tenacity of life and purpose enabled them at the proper moment to give expression to their malignity.—*Med. Press and Circular*, Jan. 8, 1890.

Society for Psychical Research.

The American Society for Psychical Research, after existing for five years, with its headquarters in Boston, and publishing some six hundred pages of "Proceedings," at last, for pecuniary reasons, terminated its corporate existence on Jan. 14. The English society of the same name is heir to its documentary possessions, and is to keep Dr. Richard Hodgson, late secretary of the American society, as its own secretary in America. A majority of the associates of the American society have joined the English society, forming the nucleus of an American branch. Professors S. P. Langley of Washington, H. P. Bowditch of Boston, and W. James of Cambridge, are appointed vice-presidents of the Society for Psychical Research in America; but, apart from their advisory functions, there is no "organization" here,—a circumstance which will doubtless contribute to economy and efficiency of work.—*Science*, Jan. 24, 1890.

Intimations of Approaching Death.

A correspondent to the *Lancet*, Jan. 11, 1890, referring to the absence of the Emperor of Brazil from the Empress's death-bed, reflects in severe terms on what is alleged to be the rule of the profession in Portugal, and of all the Latin races, of withholding clear intimations of approaching

death till it is too late for the dying patient or his friends to express their last sentiments to each other, or for the patient to realize his position. This is a matter on which the finest moral and professional judgment is needed. We disapprove the tendency of some to add to the horrors of death by preachments of a doubtful and gloomy character. But it is right that proper intimation should be given to all concerned when the result is inevitable. It would not be right to blame the Empress's physicians without knowing more of the facts.

Eau Dentifrice.

The following is indistinguishable from the well-known *Eau Dentifrice de Dr. Pierre*:

R	English oil of peppermint	℥ lx
	Oil of aniseed	℥ xc
	Oil of cloves	℥ xc
	Oil of cinnamon	℥ xv
	Rectified spirit	f 3 xx
	Saffron	gr. x

Macerate a week, and filter.

—*National Druggist*, Jan., 1890.

Bacteriology of Influenza.

Those who have followed the character and spread of the present epidemic on the Continent and in this country must, no doubt, have come to the conclusion that, like other epidemic diseases, influenza is spread by contagium, and must be due to a living organism, a microbe. The discovery of this has been announced from Vienna. Some of the daily papers, on Wednesday of this week, brought the news that the microbe of influenza has been identified, by Drs. Maxamilian and Jolles, working in the Vienna Bacteriological Laboratory under Professor Weichselbaum. It is stated briefly that this microbe is similar to, but not identical with, the microbe of croupous pneumonia. Weichselbaum has, independently of Fränkel, of Berlin, shown that genuine croupous or fibrinous pneumonia is due, not to the bacillus of Friedländer, but to a capsulated diplococcus—the diplococcus pneumoniae—having special morphological and cultural characters. The discovery of the influenza microbe, coming from such a distinguished and reliable source, deserves in

itself careful attention, and this is enhanced by the fact that in the influenza of the present epidemic, some kind of pulmonary distemper is one of the conspicuous symptoms; and this, though generally mild and of the character of a slight bronchial catarrh, has yet proved fatal in a certain percentage of cases, terminating as severe pneumonia. On the other hand, it is necessary to bear in mind that in these fatal cases the pneumonia is not of the same nature in all cases; the *post-mortem* examination shows it to be in some instances of the character of severe catarrhal or broncho-pneumonia, while in others it is more of the nature of fibrinous pneumonia. Further, it is to be remembered that, except in these fatal cases, the disease itself in its course and symptoms has no more similarity to croupous pneumonia than to typhoid fever, and that the pneumonia, when present, is always of the nature of a secondary complication, supervening on previous pulmonary weakness (age, previous disease, or a chill caught during convalescence from the primary influenza). It is, however, premature to make any further remarks about the matter until all the details concerning the microbe and the evidence as to its claims to be regarded as the microbe of influenza are made known.—*British Med. Journal*, Jan. 25, 1890.

Cholera in Mesopotamia.

There seems to be little doubt of the advance of cholera in Asia Minor, and therefore of the increasing probability of its invading Europe. Intelligence has just been received from Bassorah stating that 3,000 fatal cases had occurred there, including the English Vice-Consul, Mr. Robertson, and two of his children.—*Lancet*, Jan. 25, 1890.

Ovarian Pregnancy.

The possibility of ovarian pregnancy is stoutly denied by many authorities, such as Mr. Lawson Tait, whilst others, including Freund, declare that such a variety of ectopic gestation really exists. Freund's evidence rests upon cases where he performed abdominal section; but pregnancy was advanced, and the primary relations of a fetal sac cannot, under the circumstances, be determined with accuracy. A sac in the midst of a Fallopian tube is visible to the

naked eye; we can all see specimens of this condition and believe. In order to believe likewise in ovarian gestation a specimen in the earlier stages, where the primary relation of the fetal sac to the ovary is evident, must be demonstrated. Such a specimen is, to say the least, very rare in museums. The *Russian Journal of Obstetrics and Gynaecology*, No. 6, 1889, contains a record of an alleged case of ovarian pregnancy. A woman, aged 27, became pregnant in October, 1887, but labor never came on, and in September, 1888, she was seized with severe fever. A suppurating ectopic gestation sac was diagnosed and laid open. The fetus, which was macerated and had attained the normal size at term, was extracted. Urine and feces came away from the cavity of the sac. During recovery the patient was seized with neuritis multiplex, and removed to a ward for lunatics, where she died seven weeks after the operation. A necropsy was performed. The left ovary was found to be rather smaller than normal; the left tube stretched, pervious, and not dilated. The fetal sac was connected with the left ovary, and its outer wall was found to be, in the opinion of Dr. Muratoff, who reported the case, a continuation of the tunica albuginea of the ovary. Dr. Reimann, of Kieff, in commenting on Dr. Muratoff's interpretation of the case, in the *Centralblatt für Gynäkologie*, December 28, 1889, displays a wholesome scepticism. The sac was probably tubo-ovarian, and had become detached from its tubal connections.—*British Med. Journal*, Jan. 25, 1890.

Cocoa-Nut Butter.

Cocoa-nut butter is now being made at Mannheim, and, according to the American Consul there, the demand for it is steadily increasing. The method of manufacture was discovered by Dr. Schlunk, a practical chemist in Ludwigshafen. Liebig and Fresenius knew the value of cocoa-nut oil or fat, but did not succeed in producing it as a substitute for butter. The new butter is of a clear whitish color, melts at from 26° to 28° C., and contains 0.0008 per cent. water, 0.006 per cent. mineral stuffs, and 99.9932 per cent. fat. At present it is chiefly used in hospitals and other State institutions, but it is also rapidly finding its way into houses or homes where people are too poor to buy butter. The working classes are taking to

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Spiritualism and Insanity.

Testators would do well to control or disguise spiritualistic tendencies, for their exhibition in any marked degree opens the door to litigation by disappointed heirs after their death. Such an action is now pending in France, and there will doubtless be a conflict of expert testimony as to the significance of a belief in the manifestations of spiritualism in relation to the sanity of the individual testator. The question, of course, must turn on the details in this particular case, for unless a belief in the supernatural is to be accepted *per se* as evidence of insanity—a doctrine somewhat in advance of the times—a leaning in the direction of spiritualism has nothing in it to stamp any one as insane. It is extravagance in belief, and not belief itself, which reveals the flaw, and this holds good whether the extravagant belief be orthodox or heterodox. Ultra-spiritualistic tendencies only constitute a variety of religious mania, and require the same proof to disqualify their possessor for testamentary disposition. Most of us are familiar enough with persons who exhibit a strange susceptibility in this direction without entailing the slightest disability in other departments of daily life.—*Med. Press and Circular*, Jan. 15, 1890.

Turfa.

The United States Consul at Bahia describes a substance called turfa, lately discovered in Brazil, at a place called Maratui, about sixty miles south of Bahia. Turfa has been found to contain the main ingredient now extracted from it by distillation, viz., petroleum, or, as it is locally called, "brazolina" or "petroleo nacional," besides paraffine, gasoline, and lubricating-oils resulting from the process. A company was formed, and the concession purchased. Machinery has been imported from England, and from four hundred to four hundred and fifty hands are employed at the mines. The company, it is stated, will manufacture fifty tons of candles per month; and if the enterprise should prove a success, it will probably interfere with the trade in

kerosene, candles, and lubricating-oils which the United States now has with Brazil and with the countries south of Brazil.—*Science*, Jan., 1890.

Women Doctors in Germany.

An association of German ladies, at a meeting a short time ago, passed a resolution agreeing to a petition being presented to the divers German governments, praying for permission to be granted to women to study medicine. The petition so far has been flatly refused by Prussia, Wurtemberg, Saxony, the Duchies of Hesse-Darmstadt, and Saxe-Weimar. This is not surprising in view of the hyper-congested condition of the medical profession in the fatherland. The States may be expected to know what is best for themselves.—*Med. Press and Circular*, Jan. 15, 1890.

What the British Soldier Eats.

In an article on the Standing Army of Great Britain, in *Harper's Magazine*, Feb., 1890, General Wolseley says that the pay of a private soldier of a line infantry regiment—which is the smallest man's rate of pay in the army—is one shilling per diem. In addition to his pay he receives a daily ration of three-quarters of a pound of meat and one pound of white bread. During peace everything else he requires as food he has to purchase from his daily pay. When on active service he is well fed free of all charge.

In addition to the daily rations, every company mess purchases tea, sugar, milk, vegetables, etc., at a daily cost of about $3\frac{1}{2}d.$ to each man. Most men also buy in their canteens beer, hot sausages, butter, jam, and other luxuries. In his recreation-room the soldier can be served at all hours with good tea, coffee, bread and butter, etc.

Death from Cayenne Pepper.

A lad living at Bacup, England, complained of a cold and his mother gave him a dose of a mixture which contained a quantity of cayenne pepper. A few minutes afterwards he was found on his knees gasping for breath, and after struggling for several minutes he expired. The physician who was called decided that death was caused by the action of the pepper on a weak heart.—*Druggist's Circular*, Feb., 1890.

NEWS.

—The Department of Public Works of Munich, Germany, is about to erect a crematory in that city.

—"La grippe" is raging in Yucatan. In the City of Merida there are from six to eight deaths from this cause daily.

—The well-known authority on pædiatrics, Dr. v. Dusch, of Heidelberg, died of the influenza on January 13, 1890.

—According to the last report of the State Board of Health of Michigan, the influenza is still on the increase there.

—The Board of Health of Newport, R. I., estimated that up to Jan. 16 fully 15,000 cases of the influenza had occurred in that city.

—Dr. v. Bergmann has been appointed to fill the late Dr. v. Volkmann's place on the editorial staff of the *Centralblatt für Chirurgie*.

—The insane asylum at Worcester, Mass., caught fire on the night of Jan. 19th. All the patients were safely rescued. Damage, \$6,000.

—The cholera continues to increase in Mesopotamia. The Ottoman Government are taking most active measures to prevent an invasion of the disease in its provinces.

—Recent statistics show that Austria contains only one hundred and eighteen homœopaths, and only forty-four of these profess to practice homœopathy exclusively.

—The *Centralblatt für Nervenheilkunde* has ceased to exist on account of the retirement of its editor, Dr. Erlenmeyer, who has published the journal for the last twelve years.

—Dr. Germain Sée is the editor of a new Parisian medical weekly journal, called *La Médecine moderne*, which will be largely devoted to the reports of important scientific societies.

—The Medical Society of the State of New York will hold its annual meeting at Albany, on Feb. 4, 5, and 6, under the Presidency of Dr. Daniel Lewis, of New York. Over fifty papers are to be presented.

—A society with the title of "The Metropolitan Medical Society" has recently been organized in New York, and will hold its meetings at the residence of members on the first and third Thursdays of each month.

—Dr. H. R. Wharton, who was elected by the Board of Charities and Correction a member of the staff of surgeons at the Philadelphia Hospital in place of Dr. J. William White, has refused to accept the position.

—The dengue fever, recently epidemic in Smyrna, has reached Spain, and has assumed a very malignant character in Madrid, Barcelona, and Seville. The deaths in Madrid, from the disease, have numbered 200 in one day.

—Dr. Benjamin Fearing, of Wareham, Mass., died suddenly on the night of Jan. 23, 1890. Dr. Fearing was a native of Wareham, and well known for his benevolence and generousness. He was an old friend of the REPORTER.

—Some four hundred of the physicians of Brooklyn have formed a protective association for the purpose of avoiding bad debts, and have published for their own information a black-list of persons who can, but do not, pay their doctor's bills.

—There were 717 deaths in Vienna during the week ending January 4, 1890, 253 more than the corresponding week of the previous year. According to the *Wiener Med. Presse*, the great increase of deaths was largely due to the prevalency of the influenza, a very large proportion being from inflammations of the respiratory organs.

—The International Committee at Geneva of the Red Cross Society have under consideration a proposal for permanently commemorating the great good which the late Empress Augusta accomplished by promoting the principles of the Red Cross and improving the methods of carrying on the work of the Red Cross Societies.

—The announcement is made that a London lady has taken up the labors of Father Damien and will go to Molokai to work among the lepers. She is Amy Fowler, daughter of Chaplain Fowler, of the Bath workhouse, London. Miss Fowler studied medicine under Pasteur in Paris. She is twenty-seven years old, and goes to the lepers under the name of Sister Rose Gertrude.

—A remarkable accident occurred at Newburgh, January 20th, by which a horse and man were severely injured and another man was killed by electricity. In this case neither the horse nor either of the men was even in contact with the wire that carried the fatal current. The current was diverted from the wire, the insulation of which had become impaired, by an iron awning post, which the horse, who was tied to it, touched with his nose. In going to his rescue the man who was killed also touched the post, but the man who was injured simply touched the body of the other.

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